

**PERCEPTIONS OF HEALTH CARE WORKERS REGARDING THE  
PARTICIPATION OF MEN IN HIV PROGRAMMES**

**BY**

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## **Declaration**

I hereby declare that this dissertation is, except where specified, my own work. It is submitted for the degree of Master of Arts in Community and Counselling-based Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

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Zandile F. Dhlamini (Mrs.)

\_\_\_\_\_ day of \_\_\_\_\_ 2007

## DEDICATION

I wish to dedicate this research project to my family who gave me the freedom to focus my attention on this project at their expense for yet another year. I may have worked night and day on this but you paid the highest price.

To my daughters, Mbalí and Sibusisiwe, thank you AGAIN for being such pillars of strength, not forgetting your willingness to be my proof readers!

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**“Masculinity is not something given to you, something you are born with, but something you gain....And you gain it by winning small battles with honour”**

**- Norman Mailer, *Cannibals and Christians***

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## **Abstract**

This study explores the perceptions of health care workers regarding men's participation in HIV programmes with the objective of identifying factors that may facilitate or hinder the participation of men in such programmes. A sub aim was to explore how perceptions regarding the effects of different constructions of masculinity may be implicated in the ways men respond to HIV programmes.

The study was conducted with permission from HIV/AIDS clinics: Thembaletu clinic in the Helen Joseph Hospital, Tshwarisanang couples' VCT clinic at Chris Hani Baragwanath hospital and two Johannesburg University campus clinics. Data was collected using a purposive sample of 8 health care workers. Each participant took part in one-on-one semi-structured interviews, which yielded the results of this study. The data was analysed using thematic content analysis.

The results showed that a majority of the health care workers perceived men to be non-participatory in HIV programmes. They perceived barriers to men's participation to be men's varied perception of fear knowing their HIV status, fear of dying and fear of the emotional consequences of testing positive such as anger and depression. Men also see counselling as a sign of weakness and as a result, they do not participate in HIV programmes. In conclusion, health care workers identified the need to develop new strategies and best suited programmes that promote HIV testing amongst men.



# Chapter 1: Introduction

## 1.1. Research rationale

Historically, literature review on men and HIV has mainly focused on homosexual men, their experiences, the impact of being HIV positive and its implications and coping mechanisms used by these men in the face of HIV/AIDS (e.g. Aggleton, 1999; Fisher, 1991; Joint United Nations Programme on HIV/AIDS (UNAIDS), in Jackson, 2002; Kalipeni & Ghosh, 2007; Mancilla, 2003;). Studies from which this literature was collaborated were mostly done in the United States of America (e.g. Helman, 2007; Martin & Hasin, 1991). However in the African continent, and specifically the sub-Saharan region, the literature has mostly focused on antenatal women, Intravenous Drug Users (IDU), orphans and HIV testing (see, for example, Gage & Ali, 2004; Harrison & Montgomery, 2001; Pool, Nyanzi & Whitworth, 2001; Potts & Marks, 2001; Robins, 2004; Treichler, 1998). Silberschmidt (2004) contends that the time has come for research to shift the focus to men's misconceptions and behaviour. Currently, little information is available on HIV and heterosexual men, particularly in the South African context (Awad, Sagrestano, Kittleson & Sarvela, 2004; Bolton, 1992; Uitenbroek, 1994). Given little information on men and HIV, more research studies are needed to understand the barriers to testing amongst men in the South African context (Awad et al., 2004; Campbell, 2003; Mgalla, Wambura & de Bruyn, 1997; Sibhaha, 2006). It seems that many men are not testing for HIV (Bowleg, 2004; Britton & William, 1999; Jackson, 2002). Understanding reasons in this study why men are not testing for HIV would be an important step towards developing new strategies and programmes that promote HIV testing amongst men. Today, due to a lack of men's participation in HIV programmes, many men do not know their HIV status (UNAIDS, 2006). This has possible implications for the spread of HIV infections. INTERFUND (2004) posits that it is only through addressing and transforming the norms, values and behaviours that endorse the perpetuation and spread of HIV infection that we have the opportunity to curb the epidemic.

Global studies around HIV and AIDS have alerted us to the number of people infected by the virus, indicating alarming increase rates in the number of new infections (Human Science Research Council (HSRC), 2007; Kaizer Family Foundation, 2005; Pharoah & Schonteich, 2003; Shisana, 2002; Whiteside & Sunter, 2000). Incidence rates were found to be on the increase globally for varying reasons, particularly mother to child transmission (MTCT), intravenous drug use (IDU) and heterosexual sex (Jackson, 2002; UNAIDS, 2002; van Donk, 2002; Whiteside & Sunter, 2000). Compared to other countries, sub-Saharan Africa was recorded as having the highest incidence rates (UNAIDS, 2002). These incidence rates were also found to be high in the adult population. The primary means of infection in South Africa were found to be Mother To Child Transmission (MTCT) and heterosexual sex (Campbell, 2001; Jackson, 2002; UNAIDS 2006; van Donk, 2002; Whiteside & Sunter, 2000).

A number of studies have been conducted around HIV/AIDS, however the increase in incidence rates indicates that the problems that exist around the pandemic are far from being resolved. To illustrate this point, individuals are still engaging in unprotected sex despite being fully aware of the dangers of such actions (Beardsell, 1994; Helman, 2007; Hunter, 2001; Jackson, 2002; Maharaj, 2001; Moses & Plumber, 1994; Uitenbroek, 1994; Upton, 2001). Behaviour change appears to be a difficult area, which has implications for easy transmission of the human immunodeficiency virus (HIV) to date. The ideas behind behaviour change models is that once people are aware of the dangers they will be more likely to have themselves tested for HIV. As Beardsell (1994) stated, assumptions were made in relation to having an HIV test, that once an individual tested HIV positive; the diagnosis would lead to behaviour change, but this is not always the case (Campbell, 2003; Helman, 2007; Kalipeni & Ghosh, 2007; Long, 2005). The study conducted by Long (2005) indicates that many mothers fell pregnant despite knowing their HIV status, putting their unborn babies at risk of mother to child transmission (MTCT).

Although educational programmes have brought HIV into the spotlight and people are aware of the dangers and ways of preventing it, HIV testing has been met with a fierce resistance especially from the men (Beardsell, 1994; Jackson, 2002; Skhosana, Struthers,

Gray & McIntyre, 2006; Walker, Reid & Cornell, 2004). Attempts to try and explain this resistance to behaviour change has been analysed using various theoretical stances and models. Beardsell (1994) asserts the importance of a proactive policy to testing. Testing for HIV gives individuals the opportunity to know their HIV status, allowing for future planning and promotes responsible behaviour (Jackson, 2002; Nkosi, 2003; Sibhaha, 2006); on a general scale when people are motivated to test for HIV, subsequent responsible behaviour contributes to curbing the epidemic (Sibhaha, 2006; Skhosana et al., 2006).

The literature on barriers to health care utilisation has identified a number of barriers to HIV testing. The studies focused on diverse groups (e.g. homosexuals, injected drug abusers, and heterosexuals) who were considered to be at high risk for HIV (Awad et al, 2004; Day, Miyamura, Grant, Leeuw, Munsamy, Baggaley & Churchyard, 2003; Shisana, 2002; Stine, 2001). Some of the barriers identified include concerns about confidentiality, fatalism, lack of anonymous testing sites, loss of courage, inconvenience, the most prominent being fear (Awad et al., 2004; Hutchinson, Corbie-Smith, Thomas, Mohanan, & del Rio, 2004); fear to lose jobs, loss of a partner, fear of dying and fear of “the emotional and psychological consequences of testing positive such as anger, depression, guilt and vengeance” (Davies, Hickson, Weatherburn & Hunt, 1993; Hutchinson et al., 2004, p.108; Kalichman, DiMarco, Austin, Luke & DiFonzo, 2003; Robins, 2004; Yarhouse, 2003).

Similarly, a number of studies that have been conducted in the HIV field have had gender as the main focus. In these studies, women have been documented as being vulnerable to HIV infection for a number of reasons namely, physiological make up, financial dependence on male partners, physical and sexual abuse, cultural contexts which also include the lack of power in negotiating sex and safer sexual practices (Jackson, 2002; Mgalla, Wambura, & de Bruyn, 1997; Perinatal HIV Research Unit (PHRU), 2005; Stine, 2001; Uitenbroek, 1994; Van Dyk, 2001; Whiteside & Sunter, 2000; Whiteside, 2002). As Mane and Aggleton (2001), Campbell (2003) and Jackson, (2002) explain, it is often

men's risk-taking behaviour of multiple partners, which places women at heightened risk of HIV infection.

Although some studies have been conducted on gender differences between males and females, more studies are still needed to explore the influence of masculinity on health and illness, particularly HIV/AIDS. It has been observed that men are more reluctant than women to participate in HIV programmes such as Voluntary Counselling and Testing (VCT) for individuals and couples, support groups for people living with HIV (PLWH) and antiretroviral (ARV) programmes (Awad et al., 2004; Brown, Sorrell & Raffaelli, 2005; Skhosana et al., 2006). According to Carter (2004), VCT practices have mainly focused on counselling women with the expectation that partners will be informed should the results be HIV positive. However, this expectation has not been met as women fear partner violence, breakdown of the relationships and/ or social stigma (Akpende, Lawal & Momoh, 2002; Fylkesnes, 2000; Kalichman et al., 2003; Mane & Aggleton, 2001; Meursing, 1997).

## **1.2. Research questions**

This study aimed to answer the following questions:

- *What are health workers' perceptions regarding men's participation in HIV programmes?*
- *How do these perceptions explain the role masculinity plays in men's participation in HIV programmes?*

## **1.3. Aim of the study**

This study aimed to explore perceptions of healthcare workers regarding factors that may facilitate or hinder the participation of men in HIV programmes. A sub aim was to explore how perceptions regarding concepts of masculinity may be implicated in the

ways men respond to HIV programmes. This is included in the research because it is argued “the global AIDS epidemic is driven by men. Men have more opportunity to contract and transmit HIV” (Campbell, 2003; Foreman, 2001; Jackson, 2002; Walker et al., 2004, p.24). Thus men are centrally involved in HIV; understanding their level of involvement will assist in tailoring suitable HIV programmes.

#### **1.4. Structure of the research report**

Chapter one discusses the background information, aims and research questions relating to the study. Chapter two focuses mainly on the literature review. Chapter three deals with the sample, data collection methods used in the study as well as the data analysis. Chapter four presents the findings of the study and a discussion, while chapter five deals with the researcher’s reflections about the research process. Chapter six discusses challenges and limitations of the study. Chapter seven presents a summary, conclusion and future research topics.

## **Chapter 2: Literature Review**

### **2.1. Introduction**

The section of this chapter will commence with a brief outline of the prevalence of HIV globally - chiefly informed by the 2006 report compiled by UNAIDS - followed by the HIV statistics in the African continent. This section also discusses the limitations of these statistics.

The literature review also discusses the link between masculinity and the spread of HIV/AIDS. This is achieved by reviewing the role played by socialisation in defining gender roles, masculinity and related expectations such as having multiple partners; the psychoanalytic understanding of masculinity, condom use, men and counselling. The review ends with looking at the role of the media in line with promoting awareness and knowledge about HIV for men.

### **2.2. HIV prevalence**

#### **2.2.1. Global trends**

Global studies around HIV and AIDS have alerted us to the number of people infected by the virus, indicating alarming increase rates in the number of new infections (HSRC, 2007; Whiteside & Sunter, 2000). There appears to have been no significant difference in the estimates in a period of five years because in 2001 40 million people were reported as living with HIV/AIDS (Mane & Aggleton, 2001; Pharoah & Schonteich, 2003; UNAIDS, 2005) and the 2006 UNAIDS report estimates 38.6 million people were living with HIV/AIDS. New infections have been reported to be in the region of 4.1 million whilst AIDS related deaths are in the region of 2.8 million (UNAIDS, 2006). Global estimates of adults living with HIV/AIDS in 2005 were 37.2 million; women and children accounting for 17.7 million and 2.3 million respectively where children accounted for 0.53 million infections (UNAIDS, 2006). Global HIV infection estimates are reported to

be in the region of 4.1 million whilst AIDS related deaths are in the region of 2.8 million with children accounting for 0.38 million deaths.

In terms of different continents and countries, HIV prevalence has been declining in India, which accounts for two thirds of **Asia's** 8.3 million prevalence among adult women (UNAIDS, 2006). The decline in Asia is attributed to the ability of some of its countries to sustain their initial preventative interventions. Statistics show indications of declines in HIV prevalence in countries such as Cambodia and Thailand due to a drop in the use of commercial sex by men and a rise in the use of condoms in both countries, as well as a decline in sexually transmitted infections and subsequently HIV (UNAIDS, 2006). However, countries such as China and Indonesia are recorded as having increases in HIV prevalence due to commercial and injecting drug users who engage in unprotected sex (Journal-AIDS, 2007; The Lancet, 2003; UNAIDS, 2006). East and Central Asia also appears to be experiencing increases as evidenced by a rise in new HIV diagnoses (UNAIDS, 2006).

The **United States of America** (with a new high of 1.2 million HIV prevalence) and other **European** countries (with estimates of HIV prevalence in 2 million people) also seem to experience a rise in their HIV prevalence rates. These new infections are evidently attributed to heterosexual sex as the main form of HIV transmission (Bolton, 1992; Campbell, 2001; Helman, 2007; Hunter, 2005; Jackson, 2002; Kawichai, Beyrer, Khamboonruang, Celentano, Natpratan, Rungruengthanakit & Nelson, 2004; Niehaus, 2005; Skhosana et al., 2006; UNAIDS, 2006).

**Latin America** experienced 140 000 new infections in 2005 resulting in the number of people living with HIV/AIDS to increase to 1.6 million and a spread of between 2% and 28% of infection rates across its countries (UNAIDS, 2006).

### **2.2.2. African continent trends**

Compared to other countries, sub-Saharan Africa was recorded as having the highest incidence rates, which in some countries have risen sharply (UNAIDS 2005; 2006). In 2001 UNAIDS estimated the prevalence in the adult population to be almost 20.6 percent for the SADC region countries and 9% for sub-Sahara. Lesotho saw an increase of about 26. 9% in the adult population aged 15-49 in the same period (Journal- AIDS, 2007; Pharoah & Schonteich, 2003; UNAIDS, 2002). UNAIDS (2006) reports significant national declines in Kenya and Zimbabwe. Evidently this is due to campaigns encouraging condom use, fewer partners and delaying sexual activity (UNAIDS, 2006). Although the report states the slight decrease of the epidemic in the region, in southern Africa the levels are still higher than most sub- Saharan countries. Uganda is the exception thus far in succeeding to reduce its infection and prevalence rates (Forsythe, Arthur, Ngatia, Mutemi, Odhiambo & Gilks, 2002; The Lancet, 2003; UNAIDS, 2002). In the 1990s, the infection rates were one of the highest in the African continent. HIV prevalence in antenatal women aged 15- 24 was in the region of 21% whilst national prevalence was recorded at 15% (UNAIDS, 2002). Initiatives such as the government's multi-sectoral approach to address and coordinate the epidemic and subsequent response to it, that includes extensive educational campaigns, supply of condoms- amongst others- saw the prevalence rates decline to a recorded 6.7% in 2005 (Forsythe et al., 2002; UNAIDS 2002).

### **2.2.3. South African trends**

*“When social change impacts our attitudes and behaviours regarding gender and the roles which women and men are expected to play, we find ourselves confronted with challenges to our traditional ways of thinking and doing. We may eagerly pursue new directions in our gender roles or stubbornly resist them”- (Lindsey, 1990, p xiii)*

In 1994 South Africa experienced the most significant change, its first democratic election, which had an impact on all its citizens socially and economically. This change cultivated hopes of better living for all, particularly those who were previously disadvantaged. However, three elections later the country is still experiencing social,



health and economic constraints including poor access to education (USAID, 2005). According to a report by USAID (2005), unemployment was estimated at 27.8% in 2003 with mostly black South Africans living below the poverty line. According to van Donk (2002), poverty increases vulnerability to infection as well as reducing the ability of people infected and affected by HIV to cope with the pandemic consequences. The most critical challenge facing South Africa is the rapidly declining health of the people as a result of the rapidly increasing HIV/AIDS rates (UNAIDS, 2006).

South Africa has the highest HIV epidemic compared to other African countries (Shisana, 2002; UNAIDS, 2006). In the late 1990s the South African HIV rate was believed to be 'at a natural limit'; between 1997- 2001 the rates were reported as having increased by 56% (Journal- AIDS, 2007; Pharoah & Schonteich, 2003). The incidence rates were found to be high in the adult population. In 2001, the prevalence in the adult population was recorded as being 17 times higher than the recorded global rate (Pharoah & Schonteich, 2003). According to UNAIDS statistics for 2006, the adult population accounted for 21% of people living with HIV/AIDS in South Africa in 2003, 21,5% in adults when compared to other countries in the Sub-Saharan region (7,5%). Statistics also showed that young men aged 15-24 accounted for 8.5- 12.8% in relation to 20.5- 30.8 % of young women of the same age range (UNAIDS, 2006). The primary means of infection in South Africa – and in other Sub-Saharan regions - is recorded as being heterosexual sex which in turn “facilitates a secondary mode of transmission, namely from mother to child” (Campbell, 2003; Jackson, 2002; UNAIDS 2006; van Donk, 2002; van Dyk, 2001; Whiteside & Sunter, 2002).

### **2.3. Limitations of HIV/AIDS statistics**

The main limitation of HIV/AIDS statistics is that current literature relies on studies that have been conducted in maternity wards. Previous research identified women as victims of HIV infection mainly due to their physiological make up. In addition, women commonly tend to get tested through antenatal visits (Jackson, 2002; Kalipeni & Ghosh, 2007; Pronyk, Kim, Makhubele, Hargreaves, Mohlala & Hausler, 2002; Shisana, 2002).

Shisana (2002) maintains that this has been the measure used in South Africa for over a decade to monitor the spread of HIV. Similarly, this form of testing identified some of the barriers to testing for men from reports obtained from pregnant women (Kalipeni & Ghosh, 2007). It also became apparent from these reports that men tended to encourage their partners to go for testing in order to diagnose their status from their partners (testing by proxy). Subsequently, reports indicated that men tended to get tested for HIV less than women did. Women who have been tested in these settings, although agreeing to being tested, it is unclear how voluntary their participation might have been. One study found that of the 77% women encouraged to get tested; there was no documentation of consent for 15% of the women (Dalzell et al., 1995) whilst a study by Denayer et al (1990) found that 116 of 340 Belgian obstetricians tested women without enlightenment or seeking their consent (in Sherr, Bergenstorm & Hudson, 2000). The likelihood therefore is that the mothers' volunteering to get tested would be based on their concern over the welfare of their unborn babies.

Shisana (2002) lists the limitations associated with this mode of testing as: targeting only a select group of sexually active and pregnant women and therefore limited in drawing conclusions on younger individuals, those who have not sexually debuted or those who are not pregnant; individuals who have taken to use preventive strategies are not represented by pregnant sample. Therefore this mode of testing and compilation of HIV prevalence statistics risks over and under estimating HIV prevalence, which may result in gross misrepresentation of HIV prevalence and infection figures (Shisana, 2002). On the other hand, it may seem that it has successfully contributed to the perception that HIV is a female disease, which may partly explain men's reluctance to get tested. A common blame is that women are promiscuous and thus responsible for HIV/AIDS (Hunter, 2005; Maharaj, 2001; Niehaus, 2005; Pool et al., 2001; Upton, 2001).

A number of researchers attribute gender inequality as a factor that influences people's vulnerability (Brown et al., 2005; Campbell, 2001; Campbell, 2003; Chimbiri, 2007; Levack, 2005; Maharaj, 2001; Mane & Aggleton, 2001; Morrell & Ouzgane, 2005; Upton, 2001). van Donk (2002) cites a research done in Thailand where men living with

HIV/AIDS are beneficiaries of more money spent on their health care than on women. Jackson (2002, p.88) cautions however that “gender inequality, violence and HIV risk also occur in affluent groups particularly where men’s wealth and earning power greatly exceed that of women.” Awad et al. (2004) and Akpende et al. (2002) observed that men are more reluctant than women to participate in HIV programmes resulting in a low demand of VCT services in some areas (Fylkesnes, 2000). According to recent research, men in South Africa were found to account for only 21% of all clients receiving VCT and are thus seen to be falling through the cracks (IRIN, 2005).

## **2.4. Men and HIV**

### **Introduction**

In terms of the above discussion regarding modes of testing, it is evident that women are over-represented in the HIV/AIDS statistics. It is important to keep in mind however that in South Africa the mode of HIV is through heterosexual intercourse (Bolton, 1992; Campbell, 2001; Helman, 2007; Hunter, 2005; Jackson, 2002; Niehaus, 2005; Skhosana et al., 2006; UNAIDS, 2006). Thus for any story there are two sides. This section of the chapter will discuss how men play a role in the perpetuation of HIV/AIDS.

### **2.4.1. The gender dichotomy**

It is a known fact that biologically (physiologically) men differ from women however this difference does not explain or determine the way each gender behaves. According to Wood (1994) and Lindsey (1990), gender is not innate, but is learnt by individuals. Lindsey (1990) states that members of a society are placed into a series of social categories or positions also known as statuses, by their societies, which determines how they will be defined, treated as well as how they will relate to each other. These positions can be acquired through achievement, through an individual’s own efforts, by being born into them or have them imposed on them involuntarily. They can also be engaged in simultaneously for example, as a male being a son, a father, a husband, a teacher and a worker etc. (Walker, 2005; Walker et al., 2004). According to Lindsey (1990) these positions are relevant in a social system only. Gender therefore would be a social

symbolic creation where societal values, beliefs are preferred ways of organising the collective life (Simpson, 2005; Winstead & Derlega, 1993; Wood, 1994). Society therefore utilises physiological characteristics to distinguish between male and female thus the terms sex and gender being used. In some cases these terms can be used to mean the same thing. The difference therefore is that while sex is physiological, gender is learnt and more complex (Mane & Aggleton, 2001; Simpson, 2005; Wood, 1994; Zlotnick, 2002).

Societal values of what makes a man (masculinity) or woman (feminism) will then be taught to individuals. This is achieved through the use of various traditions and customs, which form as a part of different cultures (Seidler, 2006). This means that from birth an individual is brought up and “encouraged to conform to gender that society prescribes for us” (Wood, 1994, p.21). These are the foundation years where girls are praised for being pretty and able to express their emotions, and boys encouraged to go after what they want and chastised for crying (Cohen, 1990; Lindsey, 1990; Seidler, 2006; White, 2001; Whiteside, 2002; Wood, 1994). Both Lindsey (1990) and Wood (1994) posit that once these societal ‘symbols’ are learnt and internalised by individuals, they become more or less spontaneous.

It follows then that the roles that each gender performs are socially engineered as well as expected. Playing the expected and socially constructed role of a man means that men have to present the different facets of this term. That is, men have to play different roles in society that are reflective of the different events of their manhood (Walker, 2005; Walker et al., 2004).

As indicated above, men are taught at an early age not to cry (not to be “sissies”) and are rather encouraged and rewarded for independence, success, competitiveness and strength (Brown et al., Cohen, 1990; Connell, 1995; Holland, Ramazanoglu & Sharpe, 1994, Hunter, 2005; Mane & Aggleton, 2001; Seidler, 1989; White, 1990; Zlotnick, 2002). Parents, who are seen as the agents of socialisation, instil behaviours that are culturally relevant, and thus tend to be more rigid and tough on their male offspring (Lindsey, 1990;

Simpson, 2005; Wood, 1994; Zlotnick, 2002). The behaviours are taught early in childhood as a preparation to be able to handle all aspects of life in adulthood. According to Hartup and Zook (1960, in Zlotnick, 2002) these behaviours are then reinforced by peers who have a similar upbringing; school activities such as subjects taught, play and active behaviour. Masculinity is one way of understanding what may be seen as the only way and sometimes the right way of being a man.

David and Brannon (1976, in Lindsey, 1990, p.162) highlight 5 characteristics that are associated with the male gender role:

- i. ““no sissy stuff”: female characteristics and qualities that include being open and vulnerable. Men are not allowed to express feelings and emotions.
- ii. “The big wheel”: success, status and the need to be looked up to
- iii. “The sturdy oak”: mainly air of toughness, confidence and self- reliance
- iv. “Give ‘em hell”: the impression of being tough, violent and daring.
- v. “Macho man”: emphasis on sexual prowess and conquests.”

The above characteristics are what denote the traditional norms of being a male, which symbolise masculinity. In addition, the most commonly known and seemingly accepted form of masculinity is the one where men are emotionally reserved, are ambitious and providers for and protectors of their families. This forms the basis of how most men identify themselves, which then makes it a stereotype. The dangers of these stereotypes are that they encourage domination of women, risk taking and promiscuous sex (Jackson, 2002; Olley, Gxamza, Seedat, Theron & Stein, 2004; Pleck, Sonenstein & Ku, 1993; Pool et al., 2001). As Zlotnick (2002, p10) puts it, “one factor that is central in understanding masculinity is the notion that with masculinity comes the ability to wield power and control over others”.

It is important to note that masculinity is not static, but changes in line with changes in societal relationships (Brown et al., 2005; Connell, 1995; Mane & Aggleton, 2001;

Zlotnick, 2002). Connell (1995) posits that it is fluid, which means that it changes to suit the context that men find themselves in. The debate over masculinity has resulted in sub-concepts of masculinity such as hegemonic masculinity, post-modern masculinity, fluid masculinity (which changes according to settings), soft versus strong masculinity as well as masculinities which encompass heterosexual, homosexual, old and new masculinities (Morell, 2001; White, 2001).

For the purpose of this study, hegemonic masculinity will be focussed on because, although Wood (1994) contends that individuals also have the potential to influence cultural meanings that are imposed on them, hegemonic masculinity refutes this and denies any deviation from its norm. Therefore this inflexibility will be crucial in understanding men's attitudes and behaviour towards the HIV pandemic and strategies aimed to prevent it.

#### **2.4.2. Hegemonic Masculinity**

The concept of hegemonic masculinity, although no longer being utilised in its strict sense, is still the basis of how men construct their masculine identities and make sense of their world (Brown et al., 2005; Campbell, 2003; Connell, 1995; Niehaus, 2005; Silberschmidt, 2004; Zlotnick, 2002). Hegemonic masculinity therefore has its roots in the patriarchal and socially accepted notion that men possess the power in relation to decision making, protecting their women and children as well as dictating sexual relations (Brown et al., 2005; Foreman, 2001; Jackson, 2002; Mane & Aggleton, 2001; Meth, 1990; Pleck et al., 1993; Simpson, 2005). Gramsci referred to hegemonic masculinity as being "about winning and holding power and the formation (and destruction) of social groups in the process" which then involves the subordination of women and exercising control of men (Meth, 1990; Gramsci n.d. in Zlotnick, 2002, p10).

Hegemonic masculinity then presents a male who is brave, strong, aggressive, resilient, who is also dominating and provokes anxiety and tends to have hierarchical relations (Connell, 1995; Meth, 1990; Silberschmidt, 2004; White, 2001). Niehaus' (2005) view of

an ideal masculine man includes being able to support a wife with children from a steady income, keeping lovers, being decisive and having the final say and having the ability to face problems head on. However, another element of being “a real man” is denoted by a man’s ability to demand sexual intercourse often, thus opening doors for multiple partners. Accordingly, hegemonic masculinity encapsulates being a heterosexual, healthy competitive male who sees women as objects, which is validated by chasing after and competing for women with other males which leads to sexual conquests (Clark & Hatfield, 1989 in Zlotnick, 2002; Hunter, 2005; Meth, 1990; Seidler, 1989; Seidler, 2006).

#### **2.4.2.1. Psychoanalytic understanding of masculinity**

According to Freud, to have a sexual identity is imperative for a male’s absolute identity (Mane & Aggleton, 2001; Meth, 1990; Seidler, 2006; Zlotnick, 2002). Sexual identity is acquired as boys go through the process of striving to become men.

When explaining human behaviour, Freud used the process of maturation, which he categorised into 5 stages. Whiteside (2002) stipulates that Freud’s theory revolves around the understanding that children are born without sexuality; rather a baby is born with the sexual energy, which gets transferred from one part of the body to the next (Wertheimer, 1970). The infant undergoes a process of maturation that is marked by maturational stages namely, *oral*, *anal*, *phallic*, *latent* and *maturity* (genital) stages (Meth, 1990; Weiten, 2001), the latter being where the sexual energy is fulfilled by adult heterosexual union (Wertheimer, 1970). Sexual awareness during childhood encompasses pleasure derived from manipulation of genitals and curiosity, which is driven by the need to understand differences between the child and another. Thus sexual traits are acquired through the child’s interaction with the environment (Lindsey, 1990; Whiteside, 2002; Wood, 1994). Of these maturational stages, Freud considered the phallic stage commonly known as the *oedipal* or *phallic stage* as the stage where the traits of masculinity and femininity are determined (Lindsey, 1990; Meth, 1990; Whiteside, 2002; Wood, 1994).

Both the boy and girl experience developmental complexities that each resolves in a different manner to the other. In the case of the boy, when he discovers the private parts he also experiences feelings of wanting to 'possess his mother' (Meth, 1990; Whiteside, 2002). This experience requires that he 'kill' his father with whom he is competing for his mother's attention. However, realising his powerlessness against his father, he fears that his father will retaliate by castrating him (Lindsey, 1990; Meth, 1990; Whiteside, 2002). Therefore to prevent and overcome this castration anxiety he has to learn to suppress his love for his mother, and in a manner of speaking be on the good books of his father by emulating him (Lindsey, 1990; Simpson, 2005). During this process, the boy learns to relate to women as other, which also signifies his acquisition of what Whiteside (2002) refers to as being normal heterosexual. As the boy approaches the adolescent phase, the repressed sexual drives begin to be associated with sexual love. By having multiple partners, the boy tries to prove that he is not castrated. According to Campbell (2001, p.277), "there is a corresponding macho lack of concern for the consequences of projecting the view that 'real men' have insatiable sexual urges and therefore have to seek unprotected sex with a large number of women". This then puts a boy at risk of HIV infection or infecting others particularly when engaging in unprotected sexual activity as part of enforcing his sexual identity.

#### **2.4.3. 'Macho, macho man, I want to be a macho man'-cultural perspective of masculinity**

*"even if a man has never made love to a woman, there is enormous pressure to pretend that he has"- (Seidler, 1989, p23).*

What is of primary importance for most young men is to demonstrate their heterosexuality, an act Niehaus (2005) describes as challenging. This is because in some instances this process involves undergoing initiation ceremonies. For an example, Niehaus' (2005) study in Bushbuckridge found that 12-year-old boys had to be initiated in a 6-week ceremony in the bush, where the primary task is to educate them about 'proper masculine conduct'. In addition, these young men undergo circumcision. Circumcision is seen to introduce them to the ambit of real manhood by dissolving their



reliance on their mothers for love and nourishment (Niehaus, 2005; Whiteside, 2002). This indicates that masculinity is not inborn, but is something that boys earn through ceremonies such as going to an initiation school. Similarly, with the Xhosa tradition, manhood is only achieved through circumcision (*ukuya entabeni*-literally translated as going to the mountain or to the bush). The discourse that exists here is the notion that one is not a man if one has not gone to *entabeni*. Therefore boys who do not go to the mountains are denied the status of *indoda* (man). In a study by Field (2001) this status is achieved upon the blood flowing after the fore skin has been cut and the boys assert their sexual identity by shouting “*ngiyindoda!*” (I am a man!).

It seems the Xhosa tradition of initiating young men into *Ubudoda* (manhood) is a very important stage for young men’s identity formation (Kometsi, 2004). Immediately after two months of initiation boys are declared ‘real’ men and encouraged to go and test their manhood. One of Kometsi’s interviewees said:

“it is perceived that when you are become an *indoda*, you become a better fucker, if I may put bluntly and guys, those who have come out of *esuthwine*, because they have been away for a long time, or whatever period, you are encouraged to go and test yourself. That is something that is encouraged” (Kometsi, 2004, p. 53).

Kometsi (2004) mentions that testing out their manhood often involves sleeping with women as sex objects and an integral part is of the performance of manhood. Jackson (2002) stipulates that a ‘real man’ cannot get satisfaction from sleeping with only one woman. Socialisation’s emphasis on achievement facilitates young men’s focus on the number of girls they have managed to score with (Meth, 1990; Wood & Jewkes, 2001) as the objective is to become a distinguished *isoka* – a Zulu term synonymous to a Casanova (Hunter, 2005); and as a result lying about their sexual dealings becomes a coping mechanism in order to meet group norms and expectations (Meth, 1990).

#### 2.4.4. Multiple partners: living the hegemonic identity

In terms of living the hegemonic identity, Hunter (2005) argues that young men tend to compete amongst each other to prove themselves as real men. This competition encourages men to engage in risk-taking behaviours such as having multiple girlfriends. In these relationships there is general expectation that men should have sex with all their partners to prove their virile masculinity. Moreover, men feel entitled to have sex with their multiple partners because they bought them gifts and also took them out to the movies (Dunkle Jewkes, Brown, Gray, McIntyre & Harlow, 2004; Hunter, 2005; Gillies, Tolley & Wolstenholme, 1996; Jarama, Belgrave, Bradford, Young & Honnold, 2007; Moses & Plummer, 1994; Niehaus, 2005; Olley et al., 2004). Niehaus (2005) regards this behaviour amongst young boys as a way of building and testing their standing with their peers. As a result, young boys always feel pressurised into having sexual relationships with multiple partners.

For many boys, courtship marks the transition of boys to ‘men’. This transition can be engaged in various ways that will exhibit characteristics of hegemonic masculinity. “Sometimes trapped into feeling they are not ‘man enough’, they [boys] will feel that it is through risky behaviour that they can affirm their masculinity” Seidler (2006, p26). Young men are expected to be knowledgeable about sex-related issues (Mane & Aggleton, 2001; Seidler, 2006; Zlotnick, 2002) and those who are not knowledgeable about sex matters are ‘othered’ as *amabhari*, *izithipa* (both terms being slang for fools) or not ‘real men’ (Campbell, 2004; Holland et al., 1994; Seidler, 2006; Walker, 2005). ‘Othering’ is a coping and protective mechanism that is used to hide the anxiety that they may have about their own vulnerability (Campbell, 2003). Therefore a ‘real man’ is a young man who is able don himself in the latest fashion brands, drive an expensive car and attract interest from a number of females (Selikow et al, 2002 in Campbell, 2001). This type of a man is said to have achieved the status of *is’khokho* or “*ingagara*” synonymous to “a real man” (Niehaus, 2005; Walker, 2005). This position earns him respect and admiration from his community.

Silberschmidt (2004) describes how men in East Africa ‘traditionally’ held the role of being the breadwinners of the family and were the protectors and played an important role in making political decisions. Cattle represented a man’s wealth, and it was through cattle that a man could pay the bride price to marry (Maharaj, 2001). A real man was represented by self-control and dignity (Silberschmidt, 2004). All this changed with colonization, as it encouraged migrant labour, with women being left behind to tend to the home and land (Helman, 2007; Hunter, 2005; Maharaj, 2001; Niehaus, 2005; Pronyk et al., 2002; Silberschmidt, 2004; Upton, 2001). Colonization changed the social system and it changed the role traditionally held by women, as they took on the roles traditionally held by men in order to support their families, while their men were away (Helman, 2007; Silberschmidt, 2004). Thus many men found it hard to find a job that allowed them to pay for their own needs and for their families at home (Niehaus, 2005; Silberschmidt, 2004). Thus the social and political change of the country terminated much of the important social role that men held, leaving them feeling redundant, frustrated and most importantly powerless (Cohen, 1990; Hunter, 2005; Niehaus, 2005; Seidler, 1989; Silberschmidt, 2004). The available ‘manly’ discourse is no longer working for them, however it was hard to find alternative discourses that were socially acceptable (Crewe, 1992; Campbell, 2005; Seidler, 1989, Whiteside, 2002). This led men to manipulate the existing discourse in order to sustain some form of power, through domination and risk taking behaviour (Brown et al., 2005; Cohen, 1990; Crewe, 1992; Holland et al., 1994; Pleck et al., 1993; Silberschmidt, 2004).

#### **2.4.5. Wrapping it up: the complexities of condom use**

Associated with this risk taking behaviour is the added risk of refusing to use condoms when having sex. Seidler (2006) posits that teenage boys may tend to resist using condoms as a result of a widespread belief that they take away the pleasure (Campbell, 2003; Helman, 2007; Jackson, 2002; Levack, 2005; Nkosi, 2003; Upton, 2001; Zlotnick, 2002). In addition to this belief is the fear of being clumsy or not maintaining an erection when using condoms particularly when there is no intimacy with their partners (Helman, 2007; Hunter, 2005; Kelly, Amirkhanian, Kabakchieva, Csepe, Seal, Antonova,

Mihaylov & Gyukits, 2004; Maharaj, 2001; Upton, 2001). Instead they would rather put themselves at risk of contracting HIV than “compromise their reputation with other men” (Seidler, 2006, p 31). This fear appears to persist well into adulthood thus sustaining the tendency towards risky behaviour, particularly through having multiple partners. Men have been found to resist condoms because they believe that they make you sick and in some instances infertile (Jackson, 2002; Levack, 2005; Maharaj, 2001; Upton, 2001).

Campbell (2004) views the migrant labour system as pertinent in the perpetuation of the practice of having multiple partners. Due to the migrant system, men could not see their families and loved ones for extended periods of time. In terms of the conditions of work, they resided in single sex hostels, which are conducive to poor health, are overcrowded and dirty (Crewe, 1992; Gillies et al., 1996). The limited amount of leisure is acquired in the context of sex and alcohol (Campbell, 2003). Analogous to mining settings, a college study by Capraro (2006) found that alcohol is engaged in as part of an adventure where young men are able to break free of social restraints thus allowing them to experience the pleasures of sex and violence away from home. Fisher (1991) stipulates that many individuals hold the expectation that their sexual experiences will be intensified through consumption of alcohol, in turn making them more sexually open, romantic or less shy. Evidently, heavy drinking is seen to make men strong and assertive (Capraro, 2006). However, Krugman (in Capraro, 2006) regards alcohol consumption as a way of handling vulnerable and exposed conditions that create shameful feelings.

Campbell (2003) regards miners’ separation as being responsible for the loneliness that they experienced, coupled with the need for human intimacy. To overcome this need, most men resorted to using prostitutes and having multiple partners: “going after women” to compensate for the limited expression of their manhood and subsequent helplessness in the harsh mining conditions (Campbell, 2003, p. 32). Evidently, the urge to prove their manhood meant that these encounters involved “*inyama enyameni*” (flesh-to-flesh) sexual interactions (Brown et al., Campbell, 2003; Hunter, 2005; Jackson, 2002; Meth, 1990). Some men could not understand the risks involved by such encounters, and thus the concept of using condoms was dismissed and rejected (Agbazue, 2003; Campbell, 2001;

Chimbiri, 2007; Hunter, 2005; Jackson, 2002; Maharaj, 2001; Niehaus, 2005; Uitenbroek, 1994; Upton, 2001). The belief and reasoning of using a condom were that one could not “eat a sweet in its wrapping”; the ‘wrapping’ denies the men their right to sexual pleasure; condoms interrupt sexual activity; cause anxiety and embarrassment and ruin the excitement of *inyama enyameni* (flesh-to-flesh) (Campbell, 2003; Helman, 2007; Levack, 2005; Maharaj, 2001; Upton, 2001).

For some men the ability to impregnate a woman is also a sign of, and a social expectation of being a real man (Campbell, 2003; Helman, 2007), which is learnt at a young age (Campbell, 2003; Maharaj, 2001; Seidler, 2006; Simpson, 2005). In a marriage setting, condom use was also seen as an ‘intruder’ that also undermines trust, is associated with promiscuity and health risks for both partners resulting in infertility (Chimbiri, 2007; Maharaj, 2001; Upton, 2001). Men in Maharaj’s (2001) study also mentioned preference for condoms only with casual girlfriends. Most men were well versed with condoms as a means of family planning and prevention of sexually transmitted infections (STIs), but were cynical about their effectiveness in preventing HIV transmission. Generally men tend to have a greater number of sexual partners compared to women over the course of their life and “older men who are married tend to have had the most sexual partners” (Field, 2001; Jackson, 2002; Pool et al., 2001; Pronyk et al., 2002; Zlotnick, 2002 p.31). This corroborates with reports that HIV infection rates are high in older males and younger females (Campbell, 2003; Field, 2001; HSRC, 2007; Shisana, 2002; Skhosana et al., 2006; UNAIDS, 2006). This has a link to the context of poverty and transactional sex where young girls are likely to have relationships with men five or more years older than themselves and sugar daddies for cash and gifts (Campbell, 2003; Jackson, 2002; Niehaus, 2005; Olley, et al., 2004; Pattman, 2001). As Seidler (1989, p23) puts it, “sex is the way we prove our masculinity; it is the moment at which we can feel safe from the challenges of others”. Cohen (1990) maintains that men have an obsession with penetration, which Hunter (2005) states to be a mark of manliness for men in urban settings.

Therefore as much as miners could practice thigh sex, having penetrative sex was viewed as being more manly (Campbell, 2003; Hunter, 2005). Cohen (1990) cites Simone de Beauvoir who argued for women who suffered at the hands of their rough and brutal men who were only interested in their own selfish pleasures. Some miners are reported to have resorted to violence when their partners refused to have sex with them. “Male power especially over females appears to be central to men’s definitions of themselves; with power they are men without it they are no better than women” (Meth, 1990, p13). Similarly, young men resort to the same means with their girlfriends, and particularly when the partners want a condom to be used. This occurs because men regard having control in a sexual relationship as their prerogative (Brown et al., 2005; Jackson, Kerkhoven, Lindsey, Mutangodira & Nhaba, 2000; Jarama et al., 2007; Kelly et al., 2004; Mane & Aggleton, 2001; Meth, 1990; Pleck et al., 1993; Silberschmidt, 2004; Wood & Jewkes, 2001). Thus when steady female partners- the *regtes*- request a condom, they are seen to be unfaithful (Campbell, 2003; Jackson, 2002; Maharaj, 2001; Upton, 2001). This form of behaviour can also be viewed to attest to being a macho man and having to show who the boss is in relationships. Young men are reported to physically abuse their partners to teach them a lesson (Campbell, 2003). In this case, violence in itself attests to the ideology of being a dominant man, where the woman’s role involves being passive and submissive (Campbell, 2003; Cohen, 1990; Garson, 2005; Jackson, 2002; Jarama et al., 2007; Maharaj, 2001; Mane & Aggleton, 2001; Pattman, 2001; Skhosana et al., 2006; Westwood, 1990). Studies show that where condoms are being used it is primarily with casual girlfriends (*cherries*, *roll-ons*, *lekwafeng* (*Sotho word for secret lover*)) because there is uncertainty about their health status (Bowleg, 2004; Campbell, 2003; Maharaj, 2001; Pool et al., 2001; Pronyk et al., 2002). Maharaj (2001) maintains that condoms are likely to be used in the early stages of a relationship and are regarded as unnecessary once the relationship is seen to be authentic. A study by Peltzer (2003) showed that men tended to have a greater dislike of using condoms more than women.

In some instances men were found to believe that it is their right to have external partners despite knowing about messages to stick to one partner, reasoning that it is against their nature (Campbell, 2003; Helman, 2007; Maharaj, 2001; Upton, 2001; Zlotnick, 2002).

Walker (2005) brings attention to the irony that is brought on by this social power. “Men’s greater social power places them in a position of vulnerability regarding HIV” as a number of men have to present behaviour that is domineering and sexually aggressive in order to meet this social expectation and pressure (Walker et al., 2004, p24). Inferences may therefore be made from this observation that in their quest to behave as being powerful and aggressive, men are exposed to behaviours that include risk taking such as having multiple partners, unprotected sexual activity and in most instances excessive alcohol consumption (Jackson, 2002). Sexual knowledge and prowess are some of the expectations that perpetuate this risk taking behaviour, as they signify the all-important identity of being *the man* (Meth, 1990; Seidler, 1989; Seidler, 2006; Zlotnick, 2002).

Helman (2007) describes AIDS as a heterosexual disease largely due to extramarital sex, which he cautions has been found to be common among men in most societies. Although the prevention strategies promote faithfulness to one partner, Bolton (1992) posits that this ‘monogamy’ also has its disadvantages: a number of women who acquired HIV through heterosexually were infected by their long - term partners. The implication is that men’s cynicism about the effectiveness of condoms, physical violence, disregard of condom use in perceived steady relationships and pressure to prove their fertility (and the women’s) perpetuates the cycle of infection while increasing the rates of heterosexual HIV transmission.

On the other hand, being an *isoka* (Zulu word for a man with many girlfriends, synonymous to *Casanova*) today creates doubt in men who emulate hegemonic characteristics as other *amasoka* (plural of *isoka*) known to them die from AIDS (Hunter, 2005). This doubt and subsequent confusion is also evident in real men’s reactions and how they relate to the world around them. As a real man is known to be strong and inexpressive, men may find themselves in a trap when faced with fear of dying but also not wanting this fear to be known by others around them. Acknowledging illness is synonymous to acknowledging weakness, which is associated with being pitiful, passive and dependent (Capraro, 2006; Cohen, 1990; Lindsey, 1990; Morell, 2001; Seidler, 1989;

Wood, 1994) - characteristics which men have been socialised to reject including feelings and emotions.

## **2.5. Men and counseling**

*“Look, I don’t want long term analysis. If something is broken, let’s fix it. Tell me what I have to do and I’ll do it”- Moore, 2006, p.206*

This section of the report discusses men’s responses to counselling, counselling, as well as the effectiveness of communication and preventive strategies.

### **2.5.1. Men and shame**

Meth (1990) and Schenk (1990) in their writings have been very critical of men’s emotional development. Both these writers were drawing their views on psychoanalytic theory on how boys resolve the Oedipus complex and its impact on emotional development. Meth (1990) posits that when boys resolve Oedipus complex, they are left with the need for closeness whilst at the same time wanting to keep a distance with the opposite sex. Subsequently they learn to deny their emotions, particularly when the father does not provide the nurturance they so desire. Fathers are known to be peripheral in tasks requiring nurturance and child-care (Berger, Wallis & Watson, 1995; Connell, 1995; Lindsey, 1990; Wood, 1994). On the other hand “father- child relationships are enhanced when fathers are nurturant rather than aloof, visible rather than invisible and consistent and fair when administering discipline” (Lindsey, 1990, p.141; Pleck et al., 1993). Lindsey (1990) views the traditional ‘masculine ethic’ as discouraging fathers’ nurturing involvement with their children. This is because when fathers model a certain type of behaviour for their children, particularly sons, the sons are likely to emulate that behaviour (Lindsey, 1990; Simpson, 2005). Clearly nurturing behaviour for men betrays established patriarchal norms and family roles (Lindsey, 1990). Should a young man emulate the nurturant characteristics, he is likely to experience gender and male role conflict, which in turn evokes feelings of inadequacy and inferiority (Capraro, 2006). In other words they will be failing to meet cultural and peer standards and expectations of what it means to be a man.



Schenk (1990) on the other hand regards the Oedipal stage as being influential in men's shaming of self. During this stage, men learn through others what emotions are acceptable or not for a man. Fear and distress are considered shameful emotions because according to the stereotype of masculinity, a 'real man' does not get distressed as he is always in control; neither does he show fear because he is supposed to be strong (Cohen, 1990; Connell, 1995; Lindsey, 1990; Morell, 2001; Seidler, 1989; Simpson, 2005). Schenk (1990) maintains that through this it becomes difficult to deal with issues of death and dying because they evoke feelings of sadness and distress, which are synonymous with shame (Capraro, 2006; Robins, 2004; Simbayi, Kalichman, Strebel, Cloete, Henda & Mqeketo, 2007). Shame is related to fear as, "other men will unmask us, emasculate us, reveal to us and the world that we do not measure up, that we are not real men. Fear makes us ashamed" (Kimmel, 1994 in Capraro, 2006, p. 193). In the context of HIV/AIDS, shame manifests in different contexts: getting tested, facing up to a potential HIV positive result and the consequences of risky behaviour, which refute the projection of masculinity because it involves emotional introspection and judgement against the self (Capraro, 2006; Jackson, 2002; Meth, 1990). Evidently HIV also poses a threat to hegemonic masculinity as it requires health seeking behaviour and the abandonment of risk behaviour, particularly sexual risk behaviour. In other words HIV unmasks men and their vulnerability. According to Forsythe et al. (2002), one of the strategies for addressing the HIV/AIDS pandemic is to provide people with the opportunity to know their status, which entails testing through counselling. Implications of getting tested include being rejected, discriminated against and stigma by family and friends and therefore a number of people do not want to get tested (Agbazue, 2003; Beardsell, 1994; Castle, 2003; Jackson, 2002; Levack, 2005).

### **2.5.2. Counselling**

Counselling is the most challenging emotional experience that an individual can take. It focuses on the relations and interactions between individuals and their environment with the expressed purpose of reducing the effect of environmental and institutional barriers that impede individual success (Brems, 2001). It is a process that helps people by

assisting them in making decisions and changing behavior. Counselling therefore aims to enable people to be more passionate consumers of life.

#### **2.5.2.1. Voluntary counseling and testing (VCT)**

Voluntary Counselling and Testing (VCT) is “the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV” (UNAIDS, in Sibhaha, 2006, p.7). It is also the prime prevention strategy in South Africa (Kaizer Family Foundation, 2005; Nkosi, 2003; Sibhaha, 2006; van Donk, 2002). It involves “qualification, context as well as philosophical foundation that informs the counsellor’s approach” (Nkosi, 2003, p13). Two approaches have been commonly used in VCT: the behavioural and humanistic approaches (Nkosi, 2003) and these are discussed below.

The behavioural approach’s main aim is to modify behaviour and to change observable behaviour (Nkosi, 2003). Assumptions were made in relation to having an HIV test, that once an individual tested HIV positive, the diagnosis would lead to behaviour change (Beardsell, 1994) that would lead to the prevention of further infections and behaviour towards treatment (UNAIDS, 2006). However, a study conducted in 2005 proposed that men were less likely to access VCT services probably due to being unfamiliar with the process of counselling as well as the fearing of their statuses being disclosed and subsequent stigmatisation (Cullinan, 2006; Hollander, 2003; IRIN, 2005; Kalipeni & Ghosh, 2007; Levack, 2005). In addition, other men were reported as perceiving knowledge from testing as a burden and thus preferred not to know their HIV status as a result (Levack, 2005; Siegfried, 2005). The behavioural approach although seemingly addressing prevention of risk behaviour, it is also regarded as being authoritative and disempowering for individuals who prefer to be in control. Men are likely to experience this approach as disempowering despite it not encouraging emotional exchange with and support from the counsellor (Nkosi, 2003). In addition Beardsell (1994) and Nkosi (2003) posit that it does not cater for gender dynamics and power relationships in addition to not being conducive for long- term trauma, which may be as a result of an HIV positive

diagnosis. Similarly, 'doctor- patient' difficulties are being experienced through communication (use of jargon) and there being no sense of support thus reducing the probability of change in behaviour (Hatchett et al., 2004).

The humanistic approach, although client centred, focuses on feelings, empowers individuals to solve their own problems and is seemingly applicable in the HIV context, it is seen to promote individualism to problem solving and thus contradictory of African collectivism. Similarly, in the HIV context, family support is essential. On the other hand, it is effective when it is consistently applied- VCT is a short- term intervention (Nkosi, 2003). In this context, focusing on feelings for a man would 'reduce' him to being a 'sissy' and not a man; he would rather discuss 'sensitive' matters in the company of his peers who are likely to provide him with an acceptable manly solution to his problems. According to Ratele (2001, p.241), 'ouens' speak more frankly amongst each other than they would with women and other individuals, as they are "less guarded, unrehearsed so more revealing and thus more 'real' because the speakers assume (sometimes wrongly) that they share a reality."

Attempts to try and explain men's resistance to behaviour change has been analysed using various theoretical stances and models without much success. Meth (1990) argues that men are more likely to be distrustful and defensive when some of their sexual behaviours are questioned, as they believe that sex should be an unvarying occurrence irrespective of what transpires in their lives. Surprisingly, little research has been done in heterosexual behaviour compared to the gay male behaviour (Bolton, 1992). This appears to be true on a global scale, hence this study being conducted.

#### **2.5.2.2. To educate or not to educate?**

Bolton (1992) maintains that the goal of prevention endeavors is to get individuals to reduce risk-taking behaviours; these are mostly done through the media. Media representations that contain important information about HIV/AIDS seem to target the

stereotypical South African ideology of gender, which Wilton (1997) argues sustains and creates a process of identification with these stereotypical representations. Cohen (1990) argues that the media tends to glamorise sex. Meth (1990) corroborates this by highlighting movies such as James Bond- whose trade mark includes bedding a number of women- and Buddy Holly's song "Maybe baby, I want you tonight" which he regards as suggesting that women are objects to be wanted and conquered. Men are thus subtly motivated to emulate these suggested representations of sexual identity, inevitably maintaining problematic behaviours. Strate (2006) on the other hand illustrates this by referring to beer commercials and the messages that promote masculine activity. In collaboration with Capraro's (2006) notion that men who are heavy drinkers are strong and assertive, "in the world of beer men work hard and they play hard" (Strate, 2006, p.534). Depending on the type of the commercials, the commercials endorse the transition of boys to men, the pride of accomplishment, respect and friendship of other men, the benefit of the family, with the beer being projected as the reward that men get (Strate, 2006). Another common purpose that commercials are used for is to present men who drink beer as successful in attracting a number of beautiful women. This manipulative strategy may be seen to be a way of boosting the male ego whilst encouraging the notion of having multiple partners (Strate, 2006).

On the other hand, research claims that South Africa's diversity, particularly in language, makes it difficult to run awareness campaigns on HIV that would have an impact on people's behaviour (Shisana, 2002). Shisana (2002) maintains that communication is a vital form of communicating with target audiences. However, this communication is seen to be unidirectional and selective in that it fails to target sex workers, health workers, truckers, faith based organisations and community leaders (Bolton, 1992; Shisana, 2002). It can therefore be inferred that communication is also not effective in targeting men in general.

Similarly, despite having access to numerous forms of information on HIV/AIDS from mediums such as the TV and newspapers, Castle (2003), Helman (2007) and UNAIDS (2006) caution that a large number of people are still unaware of how HIV is transmitted

and misconceptions about the epidemic are still common. This is supported by reports of people rejecting the use of condoms despite continuous advice to use them. Hence, Helman (2007), Fylkesnes (2000), Gage and Ali (2004), McKay (1993, in Zlotnick, 2002) and Kelly et al. (2004) argue that people are not necessarily motivated to look after themselves from information alone. The increase in incidence rates indicates that HIV-related problems are still far from being put to an end. Behaviour change appears to be a difficult area, which has implications for easy transmission of the human immunodeficiency virus (HIV) to date. An aspect that might shed some light on this problem of behaviour change, which is rooted in the Health Belief Model's six stages that examine barriers to HIV testing, is an individual's perception of being at risk (Awad et al, 2004; Umar, 2004). Men tend to prove their invincibility through risk taking and indulgence in sexual risk behaviours as a way of satisfying their perceived 'insatiable sexuality'. In so doing they do not behave as people who perceive themselves at risk of being infected, instead "only gay men get HIV/AIDS" and the "wives are the ones who bring the disease to the home" (Bhattacharya, Cleland & Holland, 2000, p206; Brown et al., 2005; Day et al., 2003; Garson, 2005; Peltzer, 2003; Pool, 2001, p. 612).

HIV testing for men is associated with condom use whilst having multiple partners is not (Stein & Nyamathi, 2000). It is evident therefore that communication and information are not sufficient in themselves to evoke this change. Castle (2003) regards the knowledge of someone with HIV as a good predictor of behaviour change. However, "while the goal of prevention effort is to reduce risk taking by individuals, the processes whereby this goal is accomplished are not necessarily social and they occur within specific cultural contexts" (Bolton & Singer, 1992, p.140). It would seem that targeting men as individuals may not be an effective approach. Capraro (2006) is of the opinion that men as a group feel powerful but as individuals, feel powerless. Therefore men may not be inclined to be responsive to the preventive interventions as individuals as their vulnerabilities will be uncovered in the absence of the 'male bond'. This suggests that for interventions that are aimed at men to succeed, they have to be targeted at men as groups and encourage them to embrace alternative views of masculinity (Connell, 1995).

## **2.6. Conclusion**

In this chapter an outline of HIV/AIDS statistics was presented and their limitations were evaluated. Men's response to HIV/AIDS was discussed and explored. This was done by exploring masculine traits that characterise it in relation to men and their participation in order to gain insight into its role on men in relation to HIV services. The discussion focused on culture and socialisation, multiple partners, condom use, men and counselling. The discussion ended with an evaluation of HIV awareness and knowledge.

## **Chapter 3: Methods**

### **3.1. Introduction**

This chapter aims to describe the method and process used for this research. It explains the concept of qualitative research, the method used for data collection and how this data has been analysed. It concludes with an assessment of the research's validity and reliability.

### **3.2. Research method**

#### **3.2.1. Qualitative Research**

According to Henning (2004, p1), “the type of inquiry that a researcher conducts ...will direct her to the use of certain methods, techniques and tools”. She adds that a social enquiry, which entails a prepared questionnaire requiring predetermined responses to certain items, will make it a qualitative inquiry. This study was qualitative as well as exploratory. It is qualitative because it entailed undertaking an investigation in a social realm on an issue that has social impact. As Glesne and Peshkin (1992) put it, “qualitative inquirers look to the specific, both to understand it in particular and to understand something of the world in general”. Qualitative research therefore allows for an understanding of social reality through an insider's point of view, aspiring to present something bigger than the case to the attention of others (Glesne & Peshkin, 1992).

Therefore, pertinent information was collected by interviewing the health care workers, using a semi-structured interview schedule comprising open- ended questions (appendix IV). According to Neuman (2000), open- ended responses can be explored further by utilising a semi-structured interview. These interviews were flexible and thus not constrained by the interview schedule. This means that there was an allowance to alter questions to encourage and increase the flow of the dialogue between interviewer and interviewee. According to Kruger and Welman (2001), conducting qualitative research

presents a rich portrayal of the event being studied, contributing to theory rather than testing it.

### **3.2.2. Research design**

Due to the inadequate amount of literature on the perceptions of health care professionals regarding men's participation in HIV/AIDS programmes, this study utilised general literature available on HIV/AIDS. According to Neuman (2000) a qualitative research design provides insight into attitudes, feelings, perceptions and beliefs. The goal of this research was to explore the perceptions of health care workers in the HIV/AIDS field as a basis of exploring and understanding men's experiences relating to participation in the different HIV/AIDS programmes. Therefore the research's design is based on qualitative exploration that seeks to identify significant themes regarding men's participation in HIV/AIDS programmes. This design is therefore advantageous in how people understand and make sense of their world. Based on this exploratory nature, the results that will be presented may serve as a foundation for future research in this area.

## **3.3. Sampling**

### **3.3.1. Method of sampling**

Selecting participants using purposive sampling was guided by the study's aim to explore the health worker's perceptions on the participation of men in HIV programmes. Purposive sampling is a non-probability sampling method, which is seen to be logical in answering qualitative problems "such as discovering what occurs, the implications of what occurs, and the relationship linking occurrences" (Honigmann, 1982, in Merriam, 1998, p61). Participants who make up a purposive sample are therefore selected based on their specific experience and expertise (Merriam, 1998). The study's exploratory nature thus demanded that information be collected from individuals who are in a specific setting and therefore have insight into the attitudes and meanings attached to certain behaviour (Neuman, 2000). The sample size was chosen as a starting point into exploring men's experiences in relation to accessing HIV/AIDS programmes in the South African context. The sample thus comprised of eight clinic personnel from three HIV clinics, 2



nurses and 6 lay counsellors. Purposive sampling requires that a selection criteria be used in choosing participants which will reflect the purpose of the study and thus serve as a guide for the process to be followed (Merriam, 1998). The inclusion criteria for this study required that:

- the potential clinic personnel participants be working in the HIV field at the clinic for a minimum of two years and
- have regular contact and interaction with men who visit any of the units.

#### **3.3.1.1. Research Participants**

The age of the participants falls in the range of 23- 65. Two of the participants are female nursing sisters working in university campus clinics, two female lay counsellors working at Helen Joseph's HIV clinic and university campus clinic respectively, and four males working as lay counselors- two at Helen Joseph's HIV clinic one at a university campus clinic and one at Tshwarisanang Couples Clinic at Chris Hani Baragwanath Hospital. Due to challenges experienced (see chapter 6) during the sampling process, participants' level of experience in the HIV field ranges from a minimum of six months,- rather than the stipulated requirement of two years- to a maximum of twelve years. Each participant has regular contact with men who call at their clinics. In the case of university campus clinics, participants have contact with both students and staff.

#### **3.3.2. Sampling Procedure**

Permission was sought from the University of the Witwatersrand's ethics committee to conduct this research. This process included the committee's evaluation and approval of the consent forms, audio tape consent forms and the participant informed consent forms as well as the data collection instruments. Relevant clinic directors, who act as the gatekeepers, were contacted and provided with this approved information pertaining to the research in order to gain access to potential participants (Breakwell, 1995). Upon

meeting the personnel, relevant and potential participants were identified by the directors and were informed about the research, its aims, the research process and the participants' roles in it. The personnel's decision to participate was entirely voluntary.

Upon volunteering, participants were provided with the participant information sheet outlining the purpose of the research, what is expected from possible participants, what their rights are should they agree or disagree to take part in the study (see appendix I, p98). The form also assured the participants of the researcher's highest regard for confidentiality. Signed consent forms were provided to and signed by the participants in line with research ethical standards. A template of the relevant form is included as appendix II.

### **3.4. Procedure and data gathering**

The study entailed collecting data from an HIV/AIDS clinic of the Helen Joseph Hospital, Tshwarisanang couples' VCT clinic at Chris Hani Baragwanath hospital and two university of Johannesburg campus clinics.

Although participants were given the participation information sheet before the interviews were scheduled, only three of the participants had read it on the day of the interview. On the day of the interview, participants were greeted, and asked if they had read and understood the participant information sheet, if they had not read or understood the participant information sheet they were asked to do so before the interview began. All participants had no problems or questions relating to the participant information sheet. The researcher handed out the two consent forms upon participants' agreement to continue with the interviews. One consent form was for agreeing to participate in this research study and the other was for agreeing to use an audio tape recording device. All participants agreed to the terms of the participant information sheet and all the consent forms were signed.

Each of the interviews took place in a counseling room, on a one to one basis with the interviewer and the interviewee. The counseling rooms were chosen in order to ensure that the environment was quiet, with as little interruption from noise and disturbance by people as possible. All of the interviews took place during business hours on an appointment basis. The seating position of the interviewer and interviewee were directly opposite each other.

The interview itself commenced once both researcher and participant were seated, and the researcher verified readiness by asking, "Should we start?" Before commencing with the specific interview questions, the researcher asked the participants 7 biographical questions, concerning the interviewees experience and background in the HIV and AIDS field. At this point the audio tape recording device was switched on and in addition, the biographical answers were also recorded on paper. The completion time for interviews ranges between 15 minutes for the shortest interview, to 60 minutes for the longest interview. The interview was guided by an approximately two-page document entailing both the biographical information and the open- ended questions intended for the generation of qualitative data for the study.

The audio taped interviews were conducted in English and transcribed verbatim, as well as in Zulu and Sesotho, which were translated and then transcribed by the researcher. With translation there is the risk of losing the meaning conveyed by participants; the difficulty may lie with not being able to translate certain words. As the researcher is a Zulu and Sotho speaker, the effort was made to keep translation to the format of the participant's information as much as possible. Where certain words or phrases could not be translated, their meanings were provided.

Although the intention of the study was to conduct interviews in English, it was seen to be necessary for participants to express themselves in their mother tongue. This avoided any discomfort for participants and allowed for easy expression, articulation of their ideas and thus more information. To ensure that confidentiality is upheld, subsequent to the interviews the tapes were stored in a secure place during the transcription period.

### **3.5. Ethical considerations**

As noted earlier in the chapter, permission was sought from the heads of Helen Joseph's Thembaletu, university campus health and Chris Hani Baragwanath hospital's Tshwarisanang Couple clinics. The researcher complied with all procedures outlined in the 'participant information sheet'. The aims and the benefits of the study as well as the participants' roles were explained to both the heads and potential participants. Upon volunteering, the participants were given subject information sheets with the researchers name and contact details, aims and objectives of the study, criteria for participating in the study and language to be used for the study. Included with that were the consent form and permission to use an audio- tape to record the interviews. Prior to every interview participants were asked whether they were still willing and ready to go ahead with the interviews. At this stage they were reminded of the aims of the study and asked to sign the consent forms upon agreeing to go ahead.

Participants were interviewed on a one on one basis in enclosed rooms. There were no reported or observed adverse effects on the participants throughout the interviews. Anonymity of the informants in this research has been maintained by means of the use of pseudonyms, which have replaced the correspondents first and second names in the write up and the transcriptions, in order to ensure the anonymity of their perceptions.

The researcher has attempted to be respectful of all information given by the participants in this study. Participants were thanked for their time in participating in this research.

### **3.6. Data Analysis**

According to Glesne and Peshkin (1992, p127) "data analysis involves organising what you have seen, heard, and read so that you can make sense of what you have learnt". From working with the data, the process involves the creation of explanations, the development of theories and linking the stories you have with others (Glesne & Peshkin, 1992). The health care workers' responses to a semi- structured interview schedule were used to identify themes that would be relevant for the study, through the process of

thematic content analysis. The participants' responses were transcribed verbatim to allow for easy analysis of the texts. The content of the data was analysed for themes and meaning through recurrent patterns. Content analysis utilises an inductive method to categorise data by consolidating, reducing and interpreting it into categories (Weber, 1985).

Thus thematic content analysis is a continuous process that allows for emergent categories as it involves the researcher's engagement with the data. According to Krippendorff (1980) and Neuman (2000), thematic content analysis uses a set of techniques to make valid assumptions from specific texts. The first step of the analysis process involved multiple reading of the data to identify perceptions, feelings, attitudes and understanding. Content that was identified to be important for this study's investigation was consolidated into categories that were identified as being used most commonly by the participants or as holding particular meaning for answering the research question. This part of the process (categorising or coding) involved coding of as little as one word or many words and phrases with similar meanings into themes thus reducing expansive responses of the text into manageable units (Weber, 1985). General themes emanated from all the participants' recurring responses to the interview questions. Responses that seemed important for study but that were not coded were also seen to be important and thus were not discarded as they allowed for surprising findings. This is important in understanding and making meaning without having too many categories. The categorisation (or coding) stopped when no new themes emerged from the data. Themes were then categorised in accordance to interview questions but not exclusively due to their tendency to overlap.

## Chapter 4: Results and Discussion

### 4.1. Introduction

Chapter 2 of this study presented the literature that currently exists on the subject of men and HIV in South Africa. This study generated results from the subjective perceptions of health care workers based on their interactions with men. Through the process of thematic content analysis common themes and sub- themes were identified, which serve as a basis of this chapter's discussion. Therefore the discussion that ensues will integrate some of the literature that was presented in chapter 2; this will also assist in mutually substantiating and countering the literature presented.

This study aimed to explore health care workers' perceptions of how men reacted to the impact of HIV/AIDS, their participation in related HIV/AIDS programmes and how this behaviour could be influenced by masculinity.

### 4.2. Introducing the participants

The participants were 8 health care workers who have been working in the HIV field at their respective clinics with a minimum experience of six months to twelve years and also have regular contact and interaction with men who visit the clinics. The ages of the participants were in the range of 23- 65. As guided by the ethical code, participants' right to privacy, anonymity and confidentiality has been upheld by making use of pseudonyms to identify the participants in the discussion of themes. Additional identifying information of the participants is illustrated in the table below:

**Table: Identifying data of health care professionals:**

No.	Workplace	Age	Gender	Experience:
1	University of Johannesburg campus health clinic- Kingsway	Early 60's	Female	Registered Nurse, midwife, locum sister - 44 years
2	Themba Lethu HIV clinic, Helen Joseph	39	Female	Counselor (VCT, couple VCT) – 6 months

3	University of Johannesburg campus health clinic- Bunting	33	Female	Lay Counselor- 3 years
4	University of Johannesburg campus health clinic- Bunting	26	Male	Lay counselor – 3 years
5	University of Johannesburg campus health clinic- Bunting	43	Female	Professional nurse- Over 20 years, 12 years in HIV
6	Themba Lethu clinic- Helen Joseph Hospital	23	Male	Counselor (VCT, couple VCT, support groups)- 2 years
7	Themba Lethu clinic- Helen Joseph Hospital	25	Male	Counselor (VCT, couple VCT)- 7 months
8	Tshwarisanang Couples VCT clinic- Chris Hani Baragwanath Hospital	29	Male	Counselor (VCT, couple VCT, support groups)- 10 years

### 4.3. The context of emergent themes

In this study, themes were formulated through common codes that emerged from all participants. Each interview went through a process of data analysis, in order to identify emerging patterns and thus themes. This involves the selection, simplification as well as transformation of data from collection to the final results, which was employed throughout the research process.

Using participants' experiences allowed the researcher access to, and understanding of the information about men through the meaning that the participants have of these experiences. In addition to the discussion, engagement with the literature is also included in the discussion below. Raw quotation inserts or extracts from the interviews have been utilised to discuss the study's results. In line with the ethics code, **pseudonyms** have been used to maintain the anonymity of the participants.

As highlighted in previous chapters, it is important to note that these perceptions are subjective and therefore serve as a basis and contribution of information in growing literature on the subject of men and HIV/AIDS. Therefore they do not constitute the truth about men generally.

### 4.3.1. Men's Participation

The majority of the participants were of the perception that men did not participate in HIV/AIDS related programmes. A range of reasons was cited for this lack of participation and includes unwillingness due to a number of diverse elements. The perceptions that will be presented and discussed will be relating to the following issues:

- the notion that men are not health conscious,
- the perception of fear,
- the issue of confidentiality and stigma,
- HIV related knowledge
- and Counsellor's knowledge.

The discussion will end with an argument on the recommendations made by the health care workers, regarding ways to encourage men to access HIV services more than they currently do.

#### 4.3.1.1. Men are not health conscious

“In general men do not take as many opportunities as women in keeping up with HIV/AIDS- related information” (Skhosana et al., 2006, p.23). Men are not perceived to be health conscious because women have been found to utilise health services more than men do (Lindsey, 1990; Zlotnick, 2002). Being health conscious implies that individuals have an awareness of risks that may affect one's health. A middle aged man in Garson's (2005) study revealed that men are cowards when it came to facing health related issues, and HIV in particular. Evidently, "we are weak and ignorant about our health" (middle aged male participant in Garson 2005, p5.). When men are compared to women, who are seen to be responsible in taking care of themselves regarding health related issues, men tend to fare poorly.

*“I think men generally aren't health conscious isn't it?” – (Beth, female health care worker)*



*"...you find them smoking. And he has TB also."- (Pierce, male health care worker)*

*"Men don't ... take things seriously" – (James, male health care worker)*

*"It's just that a man won't consider the other side whether he protects himself or what"- (Pierce, male health care worker)*

*"Others will say "I've tested negative what will I be coming for a re-test for?"- (Stacy, female health care worker)*

### ***Denial and blame***

Denial in the HIV context refers to individuals who do not expect having an outcome that indicates being infected with HIV (Sibhaha, 2006). In addition to being health 'unconscious', men tend to deny the existence of HIV as was found by Garson (2005, p5) who stated that "male partners know "but don't want to know" and thus refuse to discuss the issue of HIV with their partners. Men were found to attribute HIV to witchcraft and other sources, and not their sexual behaviour (Brown et al., 2005; Kalichman & Simbayi, 2004).

On the other hand, when women tested before their partners and disclosed their HIV status, they would get blamed for bringing the disease into the relationship or home (Beardsell, 1994; Beckerman, 2002; Crewe, 1992; Garson, 2005; Dunkle et al., 2004; Helman, 2007; Kalichman, et al., 2003 & 2004; Pool et al., 2001). Previous research also found this to be the case. Consequences of this blame would be physical violence towards the women or the end of the relationships (Meursing, 1997). On the other hand Gift and James maintain that by not getting tested, men who may also be infected with the virus start new relationships and continue engaging in unprotected sexual activity (Foreman, 2001; Hollander, 2003; Jackson, 2002; Kelly et al., 2004; Yarhouse, 2003).

As a result, the perceptions that are created by this behaviour are that men do not participate in health related services, particularly HIV. According to **Pierce**, (a male health care worker):

*"-they tell themselves that I can't just get sick from silly things like that. When he gets better, "ha, I'm fine now" and then he stops and the moment you stop you give the virus a chance."*

The implication of this statement is that due to how men have been socialised, they regard themselves as strong and thus strive to maintain this façade against all threats to their health.

### ***When men do take the test***

In cases where men do go for HIV testing they have been reported to beat about the bush and are thus not forthcoming with information. These would be instances where they take the initiative to get tested before their partners. Evidently, they would seek VCT services when they suspect that there could be something not right regarding their health. In some instances, it would be because they suspect that they could have exposed themselves to the virus in some ways.

Men were perceived to be bullies when they came for VCT on their own and are reportedly also very impatient and want things to be done quickly. They just want to know the results and refuse any pre- test counselling:

*"It happens everyday. They'll say: "don't bother telling me about counselling, just take the blood and get done, I want to go that's it. I want to know if I'm positive or negative and then leave"- (**Pierce**, male health care worker)*

Contrary to previous research findings that individuals were unable to access HIV services because they were not available in their communities (Awad et al., 2004; Jackson, 2002), the health workers indicated that men had a tendency to test in areas outside of their communities. This may explain Fylkesnes' (2000) statement that VCT demand is low in some areas.

Based on interview discussions and also in line with the above perceptions, it appears that men also go for HIV testing in stages. It would seem that factors motivating men to test are when someone they know or an ex-partner dies, when they are sick or when they are forced to go. Most health care workers in this study indicated that men would come in when forced by their partners, family members and friends. In such instances, men are reportedly quiet and take any blame that is put on them particularly by their partners when the test results indicate HIV infection. In some instances they are seen to feel guilty for having infected their partners.

#### **4.3.1.2. Socialisation and masculinity**

The influence of socialisation and thus hegemonic masculinity may be responsible for the gender distinction on health issues. Women are socialised to be nurturing and to provide care for their children and families (Lindsey, 1990; Maharaj, 2001; Wood, 1994). This is in line with their gender role and characteristics of being emotional when compared to the male gender. Men on the other hand are not "sissies", they face challenges head on and being a real man requires bravery (Jackson, 2002; Olley et al., 2004; Pleck, et al., 1993; Pool et al., 2001). Beckerman (2002), Levack (2005) and Nichols, Speer, Watson, Watson, Vergon, Vallee and Meah (2002) found that some men did not fear dying per se, but rather had a fear of AIDS- the uncertainty of illness and dying slowly, thus a fast death was preferred. This is congruent with Brown et al. (2005) that men tend to deny their weakness, as well as Meth's (1990) notion that men tend to disregard bodily malfunctions, which would signify the weakness. Potential HIV/AIDS illness is one factor that facilitates such malfunctions. Levack's (2005, p.13) participants associated HIV testing with the beginning of "a healthy man's downfall". Thus men's lack of being health conscious may be a result of the dictation of societal expectations, which are in line with hegemonic characteristics of being strong and not showing traits typical of women like crying, as illustrated by the following extracts:

*"for others it's the background that they grew up in where "my father was like that" or "my father was not there for me I don't have anybody to talk to maybe concerning HIV issues"- (Mavis, female health care worker)*

*"The thinking that I am strong I can stand it when things get hard, they don't bother/ stress me that much I can take it. I can't show signs of weakness. So this thing when you look closely, it's from the old generation and it applies to other health issues."- (James, male health care worker)*

*"another thing is when we look at the older men, our big brothers, they also have this thing. Most of them have 'umakhwapheni' [secret partners/ lovers] and we grew up in that environment looking up to them so when we grow up we want to emulate because we think that this is the way to do things"- (James, male health care worker)*

*"I think the issue of culture also- you see as black people we are brought up knowing that you know- you'd hear people saying "a man doesn't cry" you know and that reason had an impact on the lives of males. If you are sick like you don't- we didn't- males didn't go to clinics because if you go to the clinics it's like you are not a man you know. Things related to clinics are women things- are seen as women issues."- (Nathi, male health care worker)*

*"I don't remember seeing a male cry or showing that he's deeply hurt" (Stacy, female health care worker.)*

Concomitant with the literature, black males are seen by the health care workers to have a tendency to internalise roles that emphasise physical strength, angry and reckless behaviour, the belief that women should be both submissive and strong, functional relations between males and females as well as strong bonding of the males (Campbell, 2003; Cohen, 1990; Garson, 2005; Jackson, 2002; Jarama et al., 2007; Maharaj, 2001; Mane & Aggleton, 2001; Pattman, 2001; Ratele, 2005; Skhosana et al., 2006; Westwood, 1990). Therefore a man who cries or shows traits reserved for women will not be abiding by cultural norms and standards.

Cohen (1990), Seidler (1989) and Simpson (2005) concur that men grew up using their fathers and grandfathers as role models on being a man. Cohen (1990, p36) stipulated that a man had to perform well, "to be good in bed meant acquiring experience, if you couldn't persuade a number of women to sleep with you, you were a failure". Again cultural implications are evident in that men needed to have a number of sexual partners to fulfil societal and 'cultural' obligations of being a man. Real men take risks, which includes having multiple sexual partners. The notion that men say they live for the

present or now (“*ngiphilela manje*”) correlates with the literature in that risks for men are immediate and relate to activities that are perceived to be dangerous (Lindsey, 1990; Umar, 2004).

This perception also relates to a strong view that the concept of **multiple partners** also plays a major role in the spread of HIV/AIDS. Evidently, such behaviour is started during the adolescent stages of male development, as was noted by Cohen (1990), Seidler (2006) and Meth (1990). Nathi (male health care worker) had this to say on this issue:

*“I think there are still some males who believe that thing [of having multiple partners]. Even- even from the township, boys grow up with that belief that when you have a lot of girlfriends it means that “ngiyinkakara” [Casanova] you know. And that thing if you grow up with it, you are still going to practice it because when some males look at you, they know that you have a lot of women; it’s like a way of getting respect from them, so ja, um- having more than one partner for some males- it’s still important.”*

In a university campus environment, the notion of multiple partners was seen to relate to peer pressure with first year students wanting to belong to certain groups or proving their transition to adulthood. Another view was that having multiple partners was used as a means of protecting individuals (male) from the hurts of love, particularly when their hearts had been broken before. The university setting highlights the link of health care workers’ perceptions with literature that suggests that status and respect from peers are important (Ratele, 2005; Seidler, 2006). Failure to comply facilitates such names as James put it, “*ibhari*” (a fool), which may be damaging for one’s masculine image. A participant in Levack’s (2005, p.14) study had this to say:

*“we guys like sex more than women, when you have money you know you can move from one girl to the next, that’s how girls act, even if they used to reject you. Once you have money, they come to you then, because of that you don’t want to go and test”.*

Lindsey (1990) and Woods (1994, p22) stipulate that “gender is learnt by individuals...when socialisation is effective in teaching us to adopt the gender society prescribes for our sex, biological males learn to be masculine”. Levack's (2005) participant highlights that having money commands female attention towards men, thereby promoting having multiple partners.

Similarly, in settings where individuals do not have means of financial stability, females fall prey to being dependent on men for money (Jackson, 2002; Upton, 2001), while on the other hand men learn that having money opens doors to behaviour that facilitates the maintenance of masculine notions. In most of such encounters condom use is shunned. Awareness that one's health is in danger because of such behaviour ensures that men avoid going for HIV testing, and thus allow for the perpetuation of HIV.

*"there's a sort of a thing that a lot of men have that it's manly to have many partners and the- and the other one of course is that that to wear a condom is not manly"- (Sue, female health care worker)*

*"What does it help to test 5 times and still continue having multiple partners, how does that help?"- (James, male health care worker)*

*"The concept of many partners hasn't changed, it still happens. Mmm. Faithfulness is entrenched in others but I'm looking at it practically, it's not happening."- (Stacy, female health care worker)*

*"...most can't stay faithful, they'd rather tell you that they'll cut sleeping without a condom but they'll sleep with their different partners."- (Mavis, female health care worker)*

*"Even though he may love you, but there's a place where he cheats. So the time that he pleases himself [cheats] you'll find that that is where he encounters problems... So at the end of the day it is a case of the person being positive and it's hard for a man to go back and tell the wife that he's positive."- (Gift, male health care worker)*

Having multiple partners was also related to men who cheated on their partners who may or may not be pregnant. Complications and difficulties were seen to emerge for men

when they get caught in the act of cheating or when they suspect that they might be infected during their indiscretions. In the latter case, the complications involve how the men are going to explain their HIV- positive status to their partners should they be infected. It's been recorded in some instances that culture dictates that men should have multiple partners. However, a participant in Walker's (2005) study mentioned that citing culture was just an excuse used by men and relates to the preservation of one's pride. Consequently, most men are seen to choose to keep this information to themselves and thus engage in unprotected sex with their oblivious partners thus initiating a potential sequence of HIV infection and re-infection (Hollander, 2003; Lie & Biswalo, 1996).

Nonetheless this importance is threatened by the reality of HIV. A supportive statement to this was supplied by the male health workers that, because most of the males who prefer to indulge in having multiple partners particularly in secrecy, they are faced with a dilemma when the time comes to get tested for HIV. This in turn may also explain the recurrent theme of men being afraid or being perceived to fear taking an HIV test. Levack (2005) noted that when a man has had multiple partners, his fear of testing for HIV is very high.

#### **4.3.2. Fear**

Wilson, Jaccard and Minkoff (1996, in Awad et al., 2004) found that individuals tended to decline getting tested for HIV when presented with an opportunity to test even though they initially tended to do so. Most health care workers highlighted fear as one of the prime reasons for men not getting tested for HIV. According to the Oxford dictionary (1988), fear is defined as having a feeling of apprehension and anxiety because of the presence of potential danger. Dawood et al., (2006) maintain that fear is an essential factor in determining risk behaviour. The following extracts highlight this:

*"see, being diagnosed is the big hurdle"- (Sue, female health care worker)*

*"...a person gets worried. They get really worried- I remember one time I was preparing one patient, I asked him questions based on the form that I had with me and I then asked him if he was ready to do the test. "Hhayi, I'm not ready, I'll come back another time". He NEVER came back."- (Stacy, female health care worker)*

*"I had one man who didn't want to be treated further."- (Sue, female health care worker)*

Thus fear plays a role in men going for a test or taking an HIV test. This further supports the notion that men do not seek HIV services or that they do not participate in HIV programmes (Skhosana et al., 2006). However Sue pointed out that not all men end up not coming back as she has had men who having tested HIV positive, came back the next day for treatment.

#### **4.3.2.1. Fear of getting tested**

Although reasons cited for getting an HIV test include knowing one's status in order to take necessary precautions, for most people it is an anxiety provoking process. The fear of getting tested was perceived to be stemming from men's rationalisation that once a person is diagnosed as HIV positive they are going to die or they have been given a death sentence. The following extracts highlight these points:

*"they have this tendency that the moment- once they know that they have HIV then they are dying"- (Gift, male health care worker)*

*"Some are afraid of the diagnosis because they think that once they are diagnosed with HIV they will surely die within a very short time"- (Sue, female health care worker).*

Research has found that fear is the main emotional reaction that is associated with HIV/AIDS- this fear is regarding contracting HIV, as well as fears of rejection by significant others should one have the disease (Dawood et al., 2006; Meursig, 1997; Tangmunkongvorakul, Celentano, Burke, de Boer, Wangpan and Suriyanon, 1994). In some instances, fear evokes anger and denial, where the latter according to Sibhaha



(2006) is related to individuals not anticipating an outcome of being infected. Knowing one's HIV status, when the HIV- positive results are not expected, tends to result in a number of negative consequences; negative in that they resulted in rejection, discrimination and stigma which may influence people to choose not to get tested (Beardsell, 1994). As discussed in Chapter 2, other negative consequences include depression, unemployment, loss of significant others, alcohol consumption which subsequently adds to the perpetuation of the epidemic.

Health care workers associated men's reaction to an HIV diagnosis with alcohol consumption. Alcohol consumption was reported as '*an emotional buffer*'. The notion that men are brave risk takers poses a problem when these risks produce challenges that are beyond men's capabilities. Subsequently, the emotional turmoil brought about by the realisation of failure- and therefore failure as real men, loss of power and disappointment- facilitates enlisting coping mechanisms such as drinking (Field, 2001). On the other hand, alcohol was also seen to be the cause of patients forgetting to take their medication. Research has also found that alcohol consumption impairs judgement and inhibitions thus contributing to forgetfulness and engaging in risky sexual behaviour.

Silberschmidt (2004) refers to a study done in North Africa where men were found to be depressed as result of 'economic marginalization' as well as low self-esteem. "Mental health problems such as depression have been associated with low adherence in HIV-positive adults and adolescents including one's perception of one's ability to follow a medical regimen" (Saloner, 2005, p.21). The findings of the study by Silberschmidt (2004) were that these inner instability and disappointments result in men's responses being violent towards women and children as a means of "giv[ing] respect and self respect to us men" (Silberschmidt, 2004, p49). On the other hand, men tended not have the motivation to get tested because their partner had tested (testing by proxy).

#### 4.3.2.2. Testing by proxy

This form of testing usually involves couples where the female undergoes an HIV test during pregnancy and routine antenatal visits. The partner, irrespective of the outcome of the HIV test results assumes their HIV status to be similar to the female's and thus in that manner eliminates the reason to visit the clinic. Levack (2005) also found that men preferred to wait for their partners to test where a HIV negative result meant that the male was fine but a HIV positive result tended to evoke anxiety, but not sufficient enough to get the male to go for a test. On the other hand men tend to believe that HIV (and Prevention of Mother To Child Transmission-PMTCT) is a female problem (HIV-Aids, 2006) as illustrated by the following:

*"We'll know through Nthabiseng when something happens"- (James, male health care worker)*

*"You'll find them saying "if you are negative then I know I'm also negative or if you are positive I'm also positive""- (Stacy, female health care worker).*

*"So there are men who when you mention HIV to them they say "I'll never go for testing because my girlfriend has tested you know and she's had a baby and she's negative""- (Nathi, male health care worker).*

*"...And then those who are married- one was in denial ne? So the wife had the test- he tests through the wife. The wife takes the test at work and her results are negative and he is positive. So if the wife is negative he also has to be negative"- (Gift, male health care worker)*

Maharaj (2001) adds that men tended to regard women responsible for their health overall, which includes being responsible for their sexual health, of which HIV is a part. This belief could also stem from the practice of women being tested during pregnancy and thus not relaying the significant impact of HIV on couple. Men therefore tend to measure their health using their partners' health status. Levack (2005) maintains that testing by proxy has not been recorded anywhere else and therefore should be taken up in intervention programmes. In a study by Pronyk et al., (2002) women's more frequent

testing was perceived to be a product of male labour migration, which reflects through lower patterns of males' usage of clinics. According to the health care workers, men tend to reason that it does not help to know one's status and would rather opt for not knowing. Similarly, consequences of not knowing also result in heightened anxiety, fear and paranoia:

*"Sometimes other people don't know and would say "I don't know and I don't want to know so from now on we use a condom, and exercise and so on"- (Gift, male health care worker)*

*"He wasn't sure and he thought he was losing weight and seeing other things that weren't there."- (Pierce, male health care worker)*

*"he used to be in a relationship with so and so and when he hears now that so and so is dead, he won't talk- he won't say that he'd also slept with her. He doesn't say a word. Later when he gets sick, eish, now he starts going to the gym; even if he went to the gym but the stress that he's got doesn't go away"- (Gift, male health care worker)*

*"you know what I'd rather not, akusizi [it doesn't help]. That is even if it's not on campus but ekasi [in the township], it's more of men [who] would say "I'd rather not know, I'm fine if I don't know".- (James, male health care worker)*

These rationalisations and methods of 'self diagnosis' were seen by some of the health care workers as being fuelled by ignorance. Seemingly due to fear, men choose to stay away from HIV centres, and as Stacy articulated, they only go to these centres "when they have run out of options" and it is almost too late.

#### **4.3.2.3. "Waiting until it's too late"**

Another seemingly universal perception was that men only came to seek HIV related services under duress as was also found by Hatchett et al. (2004). Although the aim of VCT is to encourage people to get tested of their own accord, some men were seen to be forced by their pregnant partners, family members or when they were very ill as illustrated below:

*"Most of the time they are pressurized by women or when they are sick which is when you'll find them coming in here"- (**Pierce**, male health care worker).*

*"...men have a tendency of not attending, they come when they are sick"- (**Gift**, male health care worker)*

*"It has to be too serious for them to seek help"- (**Beth**, female health care worker)*

*"...we want something to come up it's then [that] we want to do something"- (**James**, male health care worker)*

Congruent to findings by Brown et al. (2005), James, a male health care worker in this study, added that not informing one's partner about one's HIV status particularly when positive, meant that some men would opt to "not die alone" thus enforcing silence and secrecy and ultimately, the spread of the virus. In instances where men wait until it is almost too late because of illness from being infected with the HI virus, family members, partners and friends will force them to seek medical advice including testing for HIV. It would appear that these efforts too are met with resistance from the people who require this intervention because most health care workers mentioned that they would be **'pushed'** to come for testing.

"People who reported coerced testing were significantly more likely than other respondents to face subsequent HIV related discrimination, and many were refused treatment after being diagnosed with HIV" (Paxton et al. 2005, cited by UNAIDS, 2006, p88). The tendency seems to be that of waiting until it is too late, when they start developing AIDS related symptoms. Various reasons were cited for this, such as the fear to die quickly after diagnosis, as was found by Levack (2005) and Nichols et al. (2002) where men voiced the fear of testing as a death penalty and thus lacked the courage. The health care workers cited upbringing and the belief that as a man, "a small thing like the HI virus" could not bring one down, and another reason includes individual evaluations of previous behaviour. A hint of the influence of masculinity as a source of this resistance also came up as an attempt at an explanation, as indicated below:

*"A person shouldn't say 'I'll be tough I'm a man, I'm strong'"-(Stacy, female health care worker)*

*"They think: there's no one who'll tell me anything" - (Pierce, male health care worker)*

*"They must not tell themselves that illnesses are for females you see? Because around this concept you'd hear people joking and making comments that 'I'm not sick, I'm not a woman'-you see, jokes like that."- (Stacy, female health care worker)*

*"-when a male talks to another male sometimes they don't (laughs) they just don't take it straight like that it's like sometimes they think 'maybe he's mad, it's hearsay', they don't take you seriously. But when you speak to a female you are able to hear that she understands even when you question about what you said in the beginning she'll tell you. A male will tell you that 'hhayi man I heard you', understand?"- (Pierce, male health care worker).*

#### **4.3.2.4. Fear of loss**

Different perceptions were voiced regarding men's experiences and these factors also overlap with the concerns that men have regarding HIV/AIDS. Nonetheless, men were mostly seen to experience fear when accessing HIV programmes. Fear in this study related to issues of loss: loss of current relationships and in some instances loss of work and means of sustenance for the family (Awad et al., 2004; Foreman, 2001; Robins, 2004; Yarhouse, 2003). In line with hegemonic masculine traits, a real man has to have money and be able to provide for his family.

*"They keep quiet, look at the floor and take the blame- it looks like they are taking the blame. It seems as if they agree that they are brought the virus into the relationship, you see?"- (Stacy, male health care worker)*

*"When I get sick what will the children eat? I must persevere, I'm a man - what will the children eat when I get sick?"- (Stacy, male health care worker)*

*"At work they also want to know why he hasn't come to work, he says he was sick then they want a letter, especially where it's jobs where they work for white employers who think he's been drunk. Actually when we write letters we can't say exactly what their*

*illness is, you just write “medical” or something like that. But others [employers] force people to specify what their problem is exactly? So if it happens that he ends up not reporting to work for days then they are threatened with being fired- you’ll find a person saying “eish my brother I haven’t been to work and I’m going to be fired”- (Pierce, male health care worker).*

#### **4.3.2.5. Fear and denial**

Over and above the perception that men experience fear and denial, there is also a perception that men experience temporary shock when diagnosed as HIV positive. According to Stacy, a female health care worker, they distance themselves from the situation and also tend to pass the buck and blame others. Similar findings were made by Garson (2005):

*“...others don’t accept it, they can’t talk about it even to their own partners. You are able to see that the person is in denial because they continue sleeping without using a condom, understand, re-infecting each other. Ja. They just tell themselves “I can’t die alone””- (Pierce, male health care worker).*

According to Sue (another female health care worker in this study) “-it’s such a psychological shock to them” that they may even refuse treatment when it is offered, which corroborates the study by Wilson et al. (1996, in Awad, et, 2004). A supporting perception highlights the tendency of men to use alcohol as a buffer to their emotional turmoil following an HIV diagnosis:

*“If at all they have information it’s when they get to deal with those emotions more especially their solution most of the time becomes alcohol. They use alcohol. For disclosing too. OK, I’ll be able to deal with this but people mustn’t know”- (Gift, male health care worker).*

Findings in this study on fear correlate with the literature which identifies some of the barriers to include concerns about confidentiality, fatalism, lack of anonymous testing sites, loss of courage, inconvenience, the most prominent being fear (Awad et.al, 2004; Hutchinson et al., 2004); fear to lose jobs, loss of a partner, fear of dying and fear of “the emotional and psychological consequences of testing positive such as anger, depression,

guilt and vengeance” (Beardsell, 1994; Hutchinson et.al, 2004, p108). On the other hand this may be related to men experiencing shame in relation to their male behaviour. As discussed in chapter 2, shame is related to fear and for men this also involves experiences of being vulnerable due to an HIV diagnosis (Capraro, 2006; Robins, 2004; Schenk, 1990).

Similarly, according to some of the health care workers, men who had partners who tested positive are in denial. Some perceptions indicated that men tended to change, which also results in a change in the relationship (Kalichman et al., 2003; Miller & Murray, 1999; Tangmunkongvorakul et al., 1994). In line with the literature, the impact of HIV/AIDS includes strained relationships between partners, families, friends and neighbours thus perpetuating secrecy and isolation, fear of rejection by loved ones, fear of death, fear of disclosure and stigma which are not conducive to the prevention of HIV/AIDS (Akpande et al., 2002; Beardsell, 1994; Ford, Whetten, Hall, Kaufman & Thrasher, 2007; Kalichman et al., 2004; Maughan- Brown, 2006; Miller & Murray, 1999; Reece, 2003; Robins, 2004; Simbayi et al., 2007; Whiteside & Sunter, 2000). Some of the health care workers indicated despite the HIV diagnosis, some men and discordant couples remained together despite some instability that may be experienced as a result. Tangmunkongvorakul et al. (1994) found that stability in discordant couples was determined by five factors:

*1) The duration of the partnership*

Shorter relationships were found to dissolve more than established ones because at the time of diagnosis they are well rooted (average mean years found to be in the region of 3years).

*2) Economic constraints*

Separated women in Thailand were found to be financially able and therefore more independent compared to their still married counterparts. In the South African context women have been found to remain in relationships due to financial dependence of their partners even when the relationship involves violence (Whiteside, 2002).

*3) The role that extended family members play in the relationship*

Women were found to stay in marriage because they did not want to disappoint their parents or because there was no history of divorce in the family. Also, religion played a role in determining whether women stayed in marriage or not. Disregard of these factors may result in strained relations between family members and in some cases result in rejection. A study by Meursig (1997) found that fear of being rejected by the in-laws, accusations of witchcraft and subsequent loss of support and material possessions influenced some women to keep their HIV status a secret. In some instances they withdrew from interacting with family members to avoid hurtful comments and family members' refusal to eat food they have cooked.

*4) Existence of children from the marriage*

Women in the study by Tangmunkongvorakul et al. (1994) reported staying in marriage because they feared the emotional trauma of separating children from their fathers.

*5) Fear of stigmatisation*

Similar to being rejected by family members, women feared being stigmatised by their community through disclosing their status. Therefore they resorted to keeping it a secret.

**4.3.2.6. Fear of being seen**

Taking an HIV test in communities where individuals live is perceived to be problematic in that there is bound to be someone they know who also knows them who is either a patient (at a hospital) or a member of staff. Pool et al. (2001) noted that hospital and clinic staff tended to gossip and as a result, were not trusted with information.

This also links with the question asked whether access to HIV service centres was problematic. The response was that the services are accessible; however the imminent threat of being identified facilitates men to travel long distances to other areas in order to get help. In some instances they get to service centres early and demand that they be seen as soon as possible.



*"They think that that side it's people from ekasi [ in the township]- "so and so will see me""- (Pierce, male health care worker)*

*"they are afraid of confidentiality leaks or don't want to be seen to be going there"- (Sue, female health care worker).*

*"you find a lot of people whether individual or both [VCT/ ARV]- they come here from Vereeniging and other places. They are afraid to get their pills there"- (Gift, male health care worker)*

*"there was one from KZN another from- from where?- they are from far: KZN, Spruit [Natal spruit] and then others from nearby, Spruit, it's just that I've forgotten other places but mostly come from KZN, we get people from Mafikeng, from Taung, you see?"- (Stacy, female health care worker).*

#### **4.3.2.7. Fear of violence**

Tangmunkongvorakul et al. (1999) posit that an HIV diagnosis may have a huge impact on an individual's life. Similarly disclosing one's HIV status may have profound consequences for the individual and/ or the partner. Previous research indicates that women are victims of violence usually at the hands of their partners. HIV diagnosis has also been implicated as one of the reasons that women suffer from spousal (or partner) abuse (Jackson, 2002; Maharaj, 2001; Mane & Aggleton, 2001). Contrary to this literature, was the perception by one of the health care workers that men also feared testing or disclosing their HIV status to their partners because they fear being beaten up by the family members of their partners, clearly an important area for further investigation:

*"No, no he's not going to talk to his wife because if he talks to his wife she will tell her brothers and they will come and beat him up. And he didn't talk to his wife for a very long time"- (Sue, female health care worker).*

Saloner (2005) posits that when one lives in secrecy with HIV, it tends to involve living with guilt, shame and self-hatred whilst it also impedes disclosure and adherence to medication or therapy.

#### 4.3.2.8. Fear of labelling

The issue of discrimination was again highlighted as a perceived challenge that men faced which seemed to also impact on their ability to talk openly. As indicated above, men would rather indicate privately what their problem was than to say so in public. This links to the perception that men were reluctant to be seen in clinics, as those who see them there would then label them. According to Sibhaha (2006), the disadvantages of testing for HIV include getting labels such as “Z3”, “3 letters” or “*unesithathu*”, all denoting one having HIV. Sibhaha’s (2006) participant articulated that being branded with such negative labels results in an individual having negative view of one’s self.

*“Nobody will go into a setup where they are ridiculed or ignored or made to feel small for any reason. People won’t.” – (Sue, female health care worker)*

*“When a person thinks of coming this side, eish, “what if I go in there and I see so and so and they’ll think that I have AIDS?”- (Pierce, male health care worker)*

*“there are those who are worried about confidentiality and anonymity. Like last week at the wards, an older male that I had to see said “privacy, privacy please”- (Stacy, female health care worker)*

*“So there, people know exactly what you are there for and they come to conclusions very quickly. So it’s such things that put men off because they give you a label.”- (James, male health care worker)*

Similarly, having to wait in long queues whether for medication or a test was seen as a challenge along the issue of being recognised by people. Also linked to this perception is the issue of confidentiality and privacy.

#### 4.3.3. Confidentiality

Jackson (2002) posits that confidentiality is an essential factor relating to professional ethics. What can be deduced from defining confidentiality is that it refers to individual rights to privacy regarding spoken or written information (Oxford paperback dictionary,

2001). Therefore it can be inferred that in a professional setting, and in relation to HIV, that confidentiality would be an important factor regarding clients' HIV status. This would entail professionals in this field not disclosing any information that would be identifying to other parties without the clients' consent. Although VCT aims to honour the ethical code of practice, which relates to no harm and maintaining client information confidential, concerns around this issue were perceived to play a role in discouraging men to participate in HIV programmes. Similarly, breach of the ethical code of practice is associated with the still pervasive stigma about HIV in most communities:

*“say he’s come voluntarily for a HIV test- he doesn’t trust that that information won’t leave this place.”- (Nathi, male health care worker)*

*“they think that the moment you have HIV, like -people are going to think that I sleep around”- (Gift, male health care worker).*

*“if anybody in this house gets HIV they must get out of my house! So and so’s child, heee, has HIV”-(Mavis, female health care worker)*

Pool et al., (2001, p.610) found that patients who were HIV positive were less willing to inform staff of their HIV status as they were concerned about what the staff “might do with that information”. Similarly, a perception concerning sessions involving couples was seen to be risky in terms of maintaining confidentiality particularly when the couple is discordant. Couple discordance relates to one partner being HIV positive while another is HIV negative (Jackson, 2002). Thus the implication is that when a man is HIV positive, the likelihood is that the partner may inform others of his status. There is no guarantee of keeping such information confidential. Similarly, confidentiality was seen to be problematic where post-test counselling was done by another counsellor instead of the original counsellor who attended to the client in the pre-counselling session:

*“what if one is negative and the other is positive; where is the guarantee that somebody won’t disclose another person’s status.”- (Nathi, male health care worker).*

#### 4.3.3.1. Stigma and discrimination

Subsequent consequences include men losing their nerve and not taking the test (Simbayi et al., 2007). This would be more applicable when men feel that they are being judged based on their behaviour as a result of “judgemental attitudes towards those perceived to have themselves at risk of infection through immoral and/ or irresponsible behaviours” (Maughan- Brown 2006, p167). Other consequences include what Stacy and Gift referred to as “*suffering in silence*” which corroborates Sue and Nathi’s opinion of men being afraid to disclose. Martin (1996, in Maughan- Brown, 2006) cautions that people’s quality of life can be harmed by HIV-related stigma, which is further complicated by deep-rooted social fears and anxieties. Meursig (1997) states that the decision by individuals to disclose relied largely on what the reaction to the news was perceived to be. Thus stigma tends to interfere with preventive efforts, as infected people tend to internalise society’s response and views of HIV/AIDS (Simbayi et al. 2007).

This fear is in line with the literature, which indicates one of the barriers to testing to be discrimination (Awad et al., 2004). Discrimination comes about as a result of stigma. According to Edgar and Sedgwick (1999, p381), stigma is “is a culturally recognised attribute that is used to differentiate and discredit a person. The stigma may be physical, behavioural or social.” They posit that through identification of the stigma, an individual is lessened to a tainted and discounted entity, which will be the basis of how others relate to them, thus being separated from the whole. In relation to HIV, slight suspicion that an individual may have HIV may result in ostracism by their friends, family, colleagues and community (Castle, 2003; Edgar & Sedgwick, 1999). Thus discrimination is the vehicle upon which stigma is presented by rejecting and seeing others as failures. Thus in terms of masculinity this will refute men’s character of being and discredit and rob them of their identity. On the other hand, Stacy, Pierce, James and Gift attributed ignorance, lack of correct information and the “know -it -all” attitude to some of the behaviours that men engaged in.

#### 4.3.4. Knowledge of and about HIV

Knowledge about HIV was another perception that was associated with men's lack of participation in HIV-related services. Research findings however, have found an inverse relationship in relation to age and HIV knowledge (Peltzer, 2003). Some health care workers saw this as being 3-pronged: in relation to youth, the older adult age group and counsellors.

*“What I observe is that the young group is very ignorant- we youngsters. They don't care about such things. The older people have heard about that thing and it's killing. They have heard that it kills but they don't have the information, understand? They want to know more about that. The youngsters tell themselves they know about it”- (Pierce, male health care worker)*

*“the people's age is not the same. Like if you deal with- say a young couple comes in when you talk to them the whole process is going to be fast you know and when you speak to an older couple then you must take them through the process slowly, don't rush so that they will understand.”- (Nathi, male health care worker)*

*“What I think is that older people they under- there's most who understand better than those my age. They do listen better than my peers.”- (Pierce, male health care worker)*

*“as much as males cannot come and come in small numbers, we as counselors we are contributing to this, somewhere somehow. The way we are and present ourselves.”- (James, male health care worker).*

Pierce and Nathi highlight the ways in which different age groups respond to VCT. It appears that prior knowledge (or lack of it) determines men's behaviour and response (Dawood et al. 2006; Day et al. 2003; Peltzer, 2006) to the VCT process and possibly what they learn from it. Focus will be in relation to the two age groups whilst the discussion on knowledge and counsellors follows separately.

### *Youth and HIV knowledge*

Some health care workers were of the opinion that the youth tended to be ignorant about HIV. This ignorance may be seen to dictate the behaviour and reaction that they have towards HIV/AIDS related services.

This perception of ignorance is contrary to the HIV interventions aimed at youth (PHRU, 2005; Stine, 2001; van Dyk, 2001) in particular such as Lovelife, the promotion of male and female condom use, the promotion of abstinence and the promotion of non-penetrative sex (PHR, 2005). It may be argued that the extensive promotion by Lovelife and the media to the youth is what informs the perception that the youth seems to understand better in VCT counselling than the older adults. The information that is presented in VCT sessions is nothing new and therefore they can relate to it better and quicker. However that being the case, the measures and information imparted to them has not been successful in flagging the pandemic (PHRU, 2005). For one thing, celibacy for males is unimaginable as their sexual identity relies on it (Cohen, 1990; Seidler, 1989; Wood & Jewkes, 2001).

Some health care workers associated some of the youth's behaviour to peer pressure and in some instances socialisation (through modelling):

*“a lot of their education comes from the street and most of the time the education they do get is wrong, very wrong which puts them in a hole [trouble].” - (Mavis, female health care worker)*

This supports the conclusion made by some researchers that having information does not precipitate behaviour change (Awad et al. 2004; Campbell, 2003; Helman, 2007; Maharaj, 2001; Upton, 2001).

### *Older adults and HIV knowledge*

Previous research and related interventions aimed to address groups of the population that were perceived to be at high risk of being infected with HIV (Agbazue, 2003; Bolton,

1990; Jackson, 2002). Married and older men were not seen to be at risk, because engaging in sexual activities is seen as a youthful past time thus accordingly interventions target the youth (Jackson, 2002; Seidler, 2006; Stine, 2001). According to Stine (2001, p261), the following are misconceptions that are held regarding older adults:

- Old people are no longer interested in sex
- If they are interested no one is interested in them
- If they do have sex it's within a monogamous, heterosexual relationship
- They don't do drugs
- If they ever did, it's long ago it doesn't matter

However statistics have shown that HIV prevalence is high in the older adult age group. Part of this is that some married men prefer to have multiple partners mostly comprising of younger girls who want money for sustenance. In these transactional relationships condom use is erratic or non-existent (Campbell, 2003; Helman, 2007; Hunter, 2005; Jackson, 2002; Mgalla et al. 1997; Niehaus, 2005).

As most intervention messages are aimed at the youth some adults are perceived not to be well versed with HIV related issues. Some health care workers stated that older adults tended not to understand HIV related concepts and thus required more time during VCT sessions than it is with the youth. Despite the notion that “educated people are able generally to obtain information and translate it into action” (Mgalla et al. 1997, p.92), there seems to be no evidence to support it.

There is also the issue of literacy in terms of reading material (pamphlets) that are used as a media of promoting awareness and knowledge about HIV. Mgalla et al. (1997) and Helman (2007, p.397) argue that people may not necessarily “understand the underlying concepts” as some people / communities may not understand what the word “virus” means. Although written material is used, it is not being used effectively: men read newspapers but coverage of HIV is not targeting men via newspapers (Dawood et al. 2006). Beth stated that some of the messages that are being conveyed either during VCT

sessions or through pamphlets may not be clear enough thus contributing to the inefficiency of such methods. Carstens, Maes and Gangla- Birir (2006) corroborate this notion by maintaining that “effective communication is effective for health promotion and disease prevention” where targeted audiences should be able to understand this information in order to apply it to their behaviour. Thus using abstract items to convey important health related messages may be problematic for both literate or low literate audiences, but low literate audiences in particular. Contrary to these statements Nathi maintains that people are able to understand information irrespective of their literacy levels as they are able to seek help and clarification where they do not understand.

On the other hand the media has also been seen to some extent to have contributed to the widely held notion that HIV is a disease of ‘others’, where others are people who engage in actions that put them at risk of infection (Cohen 1990; Crewe, 1992; Shisana, 2002). Consequences of ‘*othering*’ are that the messages used in media are perceived to be intended for ‘certain’ people and thus contribute to the perpetuation of risky sexual behaviours and attitudes. Linked to this is the tendency to “view oneself as invulnerable or as less likely than others to experience negative life events” (Riddell & Sherrand, 2000 in Umar, 2004, p. 20). This is in line with hegemonic masculinity, which tends to reject characteristics that are atypical of its doctrines. According to Riddell and Sherrand (2000), people do not want to accept that their behaviour may possibly play a role in them contracting a disease or getting injured (in Umar, 2004). Lack of extensive and specific knowledge is regarded as one of the reasons behind perceptions people have about taking risks.

#### **4.3.5. Counsellors’ knowledge and training**

Taking the above into account, it would seem that counsellors have their work cut out for them when interacting with their clients. The issue of time, although not perceived as a challenge by most health care workers, was particularly important when considered for addressing the education of clients. Time allocation particularly in public hospitals was seen to impede on the counsellors’ ability to impart information.



*“I think that it’s all about information and the way counselors have been trained.”- Stacy*

*“So the idea should be to have either trained people who will deal just with information giving besides that you can also get information from the pamphlets, because the time here is little and so our information is also limited.”- (James, male health care worker)*

This may hinder effectiveness of counselling and the effectiveness of information giving, and thus knowledge that people take with them. Some health care workers perceived the inclusion of behaviour change in the VCT process as necessary.

*“I remember the time I started working as a counsellor for individuals. When you did counselling then it was about giving information, what is HIV, what is the difference between HIV and AIDS, how do you get infected with HIV and how can you positively live with HIV whereas now the focus has changed. I think what we can do now is add behavioural change within our counselling sessions you know try and deal with the people’s attitude towards HIV because I would like to assume people have information about HIV/AIDS but the thing that is short is for them to change their attitude. That is, I believe that for some people it goes a long when they change their attitude; and information on its own doesn’t change a person’s attitude.”- (Nathi, male health care worker)*

Similarly there was a perception that counsellors themselves needed to upgrade the knowledge that they had on HIV as was also highlighted by Boerma and Bennett (1997) who said that updating health workers knowledge is essential in them providing efficient service to their clients. Some health care workers in this study said that the information they had was not sufficient to make a difference during their sessions:

*“It is just a basic counselling: give info and make sure you prick the person for testing for HIV and from the results that’s when you can check whether you need to refer this person or what. But I feel that we can include behavioural change in our sessions because I think that that’s what most counsellors do: just do pre, and post” – (Nathi, male health care worker)*

Some health care workers indicated frustration from the inability to get through to individuals they interacted with. It may be inferred that this frustration stems from the

limitedness of the information that they have. However, Westburg and Guindon (2004) propose that health care workers should attempt to remain optimistic in their interactions with their clients, which would ensure that they do not restrain their clients' hopefulness when given information about their HIV status. It can be inferred therefore that when health care workers are not hopeful, there is a likelihood that they would find interactions with their clients stressful, subsequently resulting in them being exhausted or burnt out.

#### **4.3.5.1. Burn out**

Burn out is defined as the “physical and mental collapse” (Oxford paperback dictionary, 2001, p. 109). The definition implies that an individual is prone to both mental and physical exhaustion due to extreme stress or over exertion. If the hospitals are busy, the counsellors with an allotted time of fifteen minutes are likely to be overworked and thus suffer from burn out.

*“what I think is especially when doing VCT is that say you can do one client, you take a 5-minutes break, you come back again at least you have more strength because you can't do next, next, next- you need that strength. I'm telling you your head will go- at the end of the day.” - (Pierce, male health care worker)*

*“We don't have supervision and we have a lot to deal with.” - (Mavis, female health care worker)*

Thus men's pattern of participation seems to be influenced by various factors other than location or accessibility of HIV/AIDS related services. According to UNAIDS (2006, p282) “the vast majority of the more than 35 million people living with HIV [are] unaware of their HIV status”. Castle (2003) is of the notion that in order to allow people the ability to interactively structure the HIV/AIDS debate based on their needs, participatory education programmes should aim to address the issue of HIV in the context of other health risks. The notion of choosing not to test was regarded as both self-defeating and dangerous in that the people who are at risk of infection discourage the planning for their care and are therefore denied the benefits they may receive which would subsequently prolong their life (Beardsell, 1994).

Despite their different locations most health care workers agreed that generally HIV/AIDS services and programmes were easily accessible. However, it would appear that the provision of HIV-related services such as VCT may be falling behind in relation to the sexual behaviour trends in the communities that they provide services to, and thus falling short of achieving desired outcomes.

#### **4.4. Recommendations by health care workers**

##### **4.4.1. Interventions to encourage men's participation**

Forsythe et al., (2002) maintain that giving people the opportunity to know their status is one of the strategies for addressing the HIV/AIDS epidemic and as stated previously, VCT is utilised as the main preventative strategy (Bolton, 1992; Jackson, 2002; Shisana, 2002; Stine, 2001). Perceptions regarding current counselling approaches indicate that these approaches are adequate in addressing HIV testing. A number of perceptions came through from the health care workers in this study in relation to ways that could be employed to encourage men to seek health services including HIV services; these are discussed below.

Although these perceptions indicate adequate counselling approaches, there was an almost universal perception that the manner in which counselling was done, and its content, be upgraded. Judge Edwin Cameron is on record for emphasising the need for HIV tests to be a regular strategy in health institutions that offer treatment for HIV/AIDS (in Cullinan, 2006). However, the manner of testing should not involve pre-counselling because it appears to discourage people from testing, meaning that pre-counselling was relevant before treatment was available. Evidently this form of treatment has been in force in Botswana (Cullinan, 2006). According to Beth the messages that are given to people in pre- testing counselling sessions are not clear, and the information may sometimes be outdated inadvertently misinforming and misleading individuals who should benefit from them whilst aiding in the perpetuation of HIV infections. Beth also mentioned that this could be related to the manner in which counsellors relayed these messages. On the other hand, the argument for using a combination of HIV testing and

counselling was that it is perceived to have a positive effect on behaviour (Beardsell, 2004). It would seem that Judge Cameron perceives the fear of getting tested to be instrumental in the death of people with HIV/AIDS as they wait too long or avoid undergoing the test (in Cullinan, 2006).

The understanding of upgrading the system involves flexibility in terms of time allocation for VCT and the inclusion of behaviour modification in the counselling process. This shared perception also included that counsellors in the HIV field be re-skilled and that the government provided support in this regard.

*“We don’t have that much support or the ability to contribute a lot in HIV matters”- (James, male health care worker)*

*“I also feel that the government should intervene.”- (Mavis, female health care worker)*

Part of upgrading the system includes employing more males, which is seen to facilitate more participation in some settings as well as allowing for freedom of expression. This is in line with what some health care workers referred to as the belief that if a male interacts with another male, they are more likely to be understood compared to when they speak to a female. This seems to relate to another perception where women health care workers were seen to be judgemental, discriminatory and engaging in gossip as discussed previously in this chapter. Similarly, the study by Pool et al. (2001) found that participants had been refused assistance by clinic staff that knew their HIV status.

Counsellors were also seen as not motivated to do the job and that they were in it for the money.

#### **4.4.2. Men only services and support groups**

As highlighted in the literature review and in this chapter, men have been noted to be invisible in HIV programmes and in accessing these services (Skhosana et al., 2006). Inferences may be made from the health care workers' perceptions that in some instances

men may be avoiding HIV centres and being health conscious as a way of coping with the HIV threat to their masculine identity. Individuals who used avoidant coping strategies were found to experience high levels of emotional distress but are less likely to seek social connectedness such as support groups (Kalichman, Sikkema & Somlai, 1994). Although a majority of health care workers indicated that men were not taking part in HIV programmes, some stated that this was not the case. Nathi agreed that men did not participate in the past and that they now did. The perceptions that men have started to participate were based on the involvement of organisations such as Men as Partners and Men-Imbizo as well as the availability of support groups in some clinics and hospitals providing HIV services.

*“...if there are organisations for men and more clinics where there are lots of men like doctors and the like, if they could bring more of those it would be more useful”- (James, male health care worker)*

*“...you know I believe that support groups have helped a lot of couples and still do even now ...sharing their experiences helps”- (Nathi, male health care worker)*

*“Running support groups for men only where they are able to express. When men are together they talk but if you put them with women, women are going to blame men and men are going to blame women. So it becomes another kind of confusion. So male support groups could be the way to get them in.”- (Gift, male health care worker)*

Nathi attributed the change in men's behaviour to the newly implemented programmes aimed specifically at men: Men -As -Partners (MAP) and Men- Imbizo. Men attending MAP workshops are encouraged to participate in programmes to prevent domestic violence, sharing in the caring of those affected by the virus and to promote safe sex. The participants' perceptions implied that men seemed to prefer interacting with males when seeking health related help and were discouraged by having to interact with females. This perception was echoed by other male participants who also highlighted this preference and is evident in the MAP workshops, which are run by male volunteers (Siegfried, 2005).

It is reported that the ultimate goals of the Men as Partners (MAP) workshops that are organised by the international non-governmental organization EngenderHealth, are to curtail South Africa's AIDS problem through turning attitudes and behaviors, particularly those of the male participants that are seen by experts to contribute to the spread of the disease. On evaluating the impact of MAP Siegfried (2005) wrote: “there is no accurate way to measure how many HIV infections the MAP program has prevented... A study conducted in 2002 found shifts in attitudes toward women and HIV/AIDS in 139 men who had been through MAP.” Conversely, Awad et al (2004) claim that although attitudes and behaviour tend to be linked, attitudes do not necessarily predict behaviour. Beardsell (1994) cautions that changing attitudes and sexual behaviour is no overnight accomplishment as these have been influenced by beliefs and experience over a long period of time. Therefore a limited number of counselling sessions may not produce immediate results.

Although some health care workers advocated for having men only services, others were of the notion that it may not always be useful.

*“When it’s a man with another man, sometimes there’s no understanding, understand? So I think when a person comes here maybe it’s an option who they want to see, male or female”- (Pierce, male health care worker)*

*Another perception related to involving other organisations, the idea being that service providers within one setting should also work together to achieve maximum efficiency and specifically benefit service users.*

*“I think that let’s- as much as I said we should upgrade the system and more of education for people so that at least they don’t get half messages. Also dealing with psychologists might help...”- (James, male health care worker)*

*“I think once we have referral systems in place like there’s a couple that’s come to test for HIV and say they have relationship problems and we can always refer them to FAMSA where you know they’’ get help because some of the people, or couples or clients they use couple counselling as a way of dealing with the problems that they have so that is why I think, I believe that we have referral systems that are in place. Like for example we do not test people for STIs say there’s a person who wants to test for HIV and then for STIs as well we can always refer that person to the local clinic where they can get [the] help that they want.”- (Nathi, male health care worker)*

#### **4.4.3. Employ different strategies for different age groups**

As discussed above, there are perceptions that men's responses to HIV differed in terms of age and as UNAIDS (2006) statistics show that people in the age 50+ have the highest prevalence rate of HIV/AIDS thus, similarly it was discussed that this age group was more receptive to information than the younger group. Responses to this issue were as follows:

*“the behaviour or expressions of me as a counsellor as well as the age that's what sometimes makes men not ask questions or express themselves or come for VCT” – (James, male health care worker)*

*“but then you need a strategy to talk to him so that he can understand because I can't talk to him the same way I would with someone my age” – (Gift, male health care worker)*

*“...also the people's age is not the same...say a young couple comes in when you talk to them the whole process is going to be fast you know and when you speak to an older couple you have to take them through the process slowly.” – (Nathi, male health care worker)*

It would seem that understanding; flexibility, adaptability and some level of creativity and motivation are required in order to successfully interact with different ages of the male population in relation to HIV related issues.

#### **4.4.4. Talk and engage men**

The largely held perception that men do not talk is seen as problematic by most health care workers because it contributes to the notion that men are not participating and thus not voicing their opinions and emotions.

*“the more you talk about it the more you get...relieved if you don't want stress” - (Pierce, male health care worker)*

*“I don’t think they help. I don’t think they help. I don’t know, that’s my opinion. There’s too many things. Pamphlets need time for reading but one to one works because that’s the opportunity you use to educate the person and you find that they weren’t aware of a lot of things. To me it does work, and the group discussions also work. Sometimes when they are here you sit with them and talk. That is the best because they raise their opinions.”- (Beth, female health care worker)*

It is understood that in talking you educate people, and thus education is seen as important. Some perceived that people could be educated while they wait at reception, the trick being to seize the opportunity and take advantage of that time to generate discussion as well as settling people down. Similarly the setting is also seen as important in allowing men to be comfortable, open and therefore able to talk freely. Although the implication from the health care workers perceptions indicates that men do not talk when accessing HIV services, literature suggests that men actually talk more than women as was found in a study by Swacker (1975, in Lindsey, 1990).

Evidently men also tend to interrupt women more than it is the other way around as it is indicative of the distinction of power between the two sexes (Zimmerman and West, 1975 in Lindsey, 1990). Therefore the suggestion that men should be encouraged to talk more supports this power differential factor and an attempt to capitalise on it may be worth pursuing. Observations made by health care workers dealing with support groups endorse the notion by Miller and Murray (1999) and Ratele (2001) that men tended to talk more with other men because of a shared language, experience and the bond of brotherhood. However, health care workers should be cautious to make note of non-verbal communication as it also plays a role in conveying how individuals feel (Lindsey, 1990) as well as how they react to these cues.

In addition to the setting, the manner in which you approach and treat men as a counsellor is also important. All the participants reported not having their perceptions interfere with their interactions with men. The consensus was that each individual they came across was treated as an individual with separate needs. This seems to have been useful in instances where men had to return for repeat treatment as well as referrals.



The health care workers in this study also mentioned the issue of respect. In addition, an understanding of who is dealt with in terms of issues such as background, beliefs and expectations was seen to be paramount particularly when dealing with men, irrespective of the gender of the counsellor:

*“ It can be the treatment from the person who will be helping him. Look if, even if it could be a female who’ll be helping him but if he could be aware that she understands him and I think males will always need that .... but the thing is he wants you not to forget that he is a male. Even you- even I as a male, when dealing with a male- it’s not that because I’m also a male I must disrespect him you know. I still have to give him his space. And if I give him his space he’s going to give me my space.” - (Nathi, male health care worker).*

#### **4.5. Conclusion**

At the conception and inception of this research, very little information existed on studies conducted specifically with men. In the two years that have elapsed since, some research information has become available. However this information is still not sufficient in view of the statistical presentation in South Africa, being one of the countries with the highest infection rates, there is still no change towards a decline. This, despite an impressive improvement in the provision of antiretroviral medication and an increase in the number of people who have benefited from this. It is the researcher’s hope that the research that is slowly trickling in gains momentum which will aide in identifying important areas for improvement such as upgrading the skill level requirements of the counsellors e.g. they should be certified professionals who are empowered to deal with reservations they might have in dealing with clients.

In the time being though, the first step would be to try and shift our own methods of doing research and attempt to include men in these existing and upcoming ventures. Harrison (1999) maintains, “the impact of men’s social reproduction work may be gendered in that it allows men to engage in particular discourses of development” (in

Cleaver, 2002, p13). According to Cleaver (2002) men are essential partners that are needed in the political movements as well as development organisations in order to warrant that gender issues are not marginalised and under funded. Thus far men have been excluded from and mostly seen to be perpetrators of the spread of HIV (Jackson, 2002).

Additionally, AIDS programmes affect women and men differently (Mgalla et al. 1997), where men appear to also be victims of social and political change by being excluded through initiatives aimed at empowering women (Campbell, 2002; Cleaver, 2002; Skhosana et al. 2006). Therefore “intensive educational programmes targeting men and greater media reporting on the human face of the illness could do so much more to offer support and eradicate stigma” (Garson, 2005, p.5).

## Chapter 5: Self-reflection

Due to the perceived sensitivity of conducting research in the field of HIV, the researcher experienced a number of challenges in the completion of this study that spanned over a year. The initial plan of the intended research was to conduct interviews with men who have HIV positive partners. However issues around sampling and ethical dilemmas were raised in many research committees before the proposal was approved. The main question asked by the research ethics committee was regarding the means of finding the sample, which would have comprised of men only. This was seen to violate the confidentiality for both partners as well as the integrity of the hospital where the sample was sought. The researcher indicated that she would place posters in HIV clinics and in general public areas to recruit male participants. This approach was deemed time consuming and therefore not viable.

The researcher suggested as an alternative to approach the Men As Partners (MAP), an international organisation targeting to change male attitudes and behaviour in relation to HIV. Attempts were made to contact the offices of MAP but this proved unsuccessful. By this time the first year had ended and as a result of frustration, a new strategy was seen to be necessary.

The next attempt looked at using health care workers as a gateway to accessing information related to the initial idea of conducting research on men. The researcher wanted to conduct interviews with health care workers at Chris Hani Baragwanath hospital, but it seems there is research fatigue amongst health care workers. Many studies done by university students concerning HIV/AIDS are conducted in this setting. The main challenge for the researcher was to find another sample. It was a very trying moment of the research process.

It took over three months for the researcher to find a sample. At this point the researcher was despondent to the point where the initial excitement of conducting the research had waned. The task seemed unfruitful to pursue or complete because of the delays and set

backs experienced. In a last ditch attempt and due to time constraints and accessibility, a sample was sought in neighbouring Helen Joseph and University Campus health centres, where the researcher was doing her internship. The Thembaletu centre at Helen Joseph provides HIV/AIDS services to the public, which range from Voluntary Counselling and Testing (VCT) to antiretroviral medication. The University health campus offers health related services to the campus students and staff, which include VCT. In both settings participation was voluntary. The interviews were taxing on the researcher because in one centre three interviews were conducted three hours in succession. In hindsight, this turn of events may have impacted on the quality of the interviews and information gathered because:

- The participants did not have enough time to prepare for the interviews. Although most were given the participant information sheet and given an oral explanation of what the study and the interviews entailed, some were not prepared by the time interviews were done.
- The ‘crammed’ succession of interviews did not allow the researcher sufficient time to reflect on the information already obtained in order to make adjustments to enhance and modify relevant questions. As a result the semi-structured interview schedule was relied on as a guide as well as what participants brought to the interview.
- The researcher is female and researching about men and HIV. It is not clear what the impact of this was or how it influenced the findings. Female participants did not seem fazed at the initial meeting and discussion of the research aims. Male participants seemed sceptical and two seemed to volunteer from peer pressure. However, during interviews, male participants were more relaxed and informative, whilst female participants such as Beth and Sue seemed uncomfortable and guarded in their responses. It seemed as though they did not want to seem like they were ‘bad mouthing’ men and thus responded within ‘safe’ limits. This may be indicative of difficulties still inherent in

openly discussing HIV. If this is the case, it raises questions of how other professionals who may have the same difficulties then handle the HIV topic in sessions, and how this in itself plays a role in the fight or failure to fight the epidemic. Mavis on the other hand seemed to have difficulty in discussing men without talking mostly about women, which may be an influence of the current research focus.

Overall, the experience of conducting the research despite the challenges experienced was rewarding, particularly in respect to male participants who made it easy for me to forget that I was a female researcher. This enabled me to suspend my beliefs and perceptions and thus engage as an objective agent. Admittedly, there were unexpected responses but what I found most surprising was the ease and trust that male participants had in me and for that, I am grateful.

## Chapter 6: Challenges and Limitations

Methodologically, this study is limited in that a small sample size was used based on the nature and sensitivity of the research. There can therefore be no causal inferences drawn from the data as it is a rather descriptive form of subjective information, although useful in providing insight into questions investigated. As the interpretation of the perceptions of the health care workers is of a subjective quality as well as descriptive, they cannot be taken as a general representation of health care workers' experiences or as the truth in relation to men in general.

Another limitation concerned the fact that English was not the first language for most of the health care workers. This meant that health care workers found it difficult to express themselves. Thus most of the interviews were conducted in their mother tongue to facilitate comfortable expression. This involved translation during the process of transcribing. As with most translations some of the impact and importance of what was said may have been lost.

Another possible limitation is the possibility that the health care workers may have responded to some questions in a socially acceptable and desirable manner. This would imply that their responses may therefore not be reflective of their actual and true reflection of their perceptions.

It may also be argued that this study falls in the trap mentioned by Kalipeni and Ghosh (2007) that most studies tend to focus on the epidemiological study of HIV in relation to only segments of the general public that are considered to be at risk. Thus it may have overlooked the holistic elements that are at play in relation to men's behaviour and response to HIV that may be useful in designing and implementing effective and male-inclusive interventions.

## **Chapter 7: Summary, Conclusion and Future Research Topics**

### **7.1. Summary of the study**

This study aimed to explore perceptions of health care workers regarding factors that may enable or constrain the participation of men in HIV programmes. It included a specific sub aim to explore how perceptions regarding concepts of masculinity may be implicated in the ways men respond to HIV programmes. This was based on the view that men are the driving force behind the AIDS epidemic. A semi structured interview was conducted with eight health care workers at HIV/AIDS clinic of the Helen Joseph Hospital, Tshwarisanang couples' VCT clinic at Chris Hani Baragwanath hospital and two university of Johannesburg campus clinics collectively.

The study found that men did not access HIV services when compared to the women. The reasons corroborated most findings of previous research done on VCT, condom use, HIV awareness and knowledge and stigma. However, time, knowledge and stigma were seen to necessitate male impatience, fear and non-compliance with HIV medication and treatment in that they served as some of the obstacles in men's motivation to access HIV services. Contrary to the findings that HIV services were inaccessible, some men were found to travel long distances and arrive at HIV clinics very early in order to avoid meeting people who might know them and make assumptions about their HIV status.

Interestingly, despite regarding current VCT services as adequate, some health care workers highlighted the need for their improvement- such as the inclusion of behaviour change- with a main focus on personnel re-skilling. The health care workers suggested that these include empowerment through access to updated HIV information and support from the Government. In addition support was required in the form of counsellor debriefing in order to curb burn out which may impede effective provision of services.

Similarly, the health care workers recommended that services targeting men should also be run by men (men only services) in order to encourage effective service provision and interventions that men could relate to.

## **7.2. Conclusion**

Masculinity and heterosexual men have up until more recently been largely absent from HIV/AIDS literature or literature on sexuality despite the fact that it is evident that masculine sexuality plays a prominent role in the epidemic and that it has clear cultural and social implications. The unyielding nature of hegemonic masculinity is that it poses questions relating to its flexibility and thus rather than stabilise men's understanding of themselves and those around them, it causes insecurity and confusion (Seidler, 1989; Seidler, 2006; Whiteside, 2002; Zlotnick, 2002). Though the manipulation of the hegemonic discourse and representations of masculinity allow men to regain some form of control in their lives, it also restricts their movements in life.

One thing that is clear is that social changes result in new masculinities being formed (Seidler, 1989; Hunter, 2005) and HIV is one such fundamental change. Upholding hegemonic masculinity characteristics and expectations seems to be the main factor in men's resistance to HIV/AIDS prevention and transmission. Current preventive strategies and modes of information around HIV do not seem to have an impact on men's behaviour and participation in HIV programmes and may need to be re-evaluated to encourage this participation. In turn this may have a positive impact in the reduction of heterosexual HIV transmission.

## **7.3. Future research topics**

Therefore, the following areas may require further exploring by research:

- how effective are the current techniques of counselling on South African black males?
- Should HIV testing focus on only testing or counselling?



- Should the paradigm of counselling be shifted to suit the demands of the epidemic?
- The role psychologists play in the fight against HIV/AIDS

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## ***Appendices:***

Appendix I: Participant information Sheet

Appendix II: Informed Consent Form

Appendix III: Consent to Record the Interview

Appendix IV: Interview Schedule

Appendix V: Letters of Approval

Appendix IV: Interview transcripts

## ***Appendix I: Participant information Sheet***



School of Human and Community Development

*Private Bag 3, Wits 2050, Johannesburg, South Africa  
Tel: (011) 717-4500 Fax: (011) 717-4559*

Good day.

My name is Zandi Dhlamini. I am a Masters in Community- Based Counselling Psychology student at the University of Witwatersrand. As part of my studies I am required to conduct a research project. My research aims to explore your perceptions regarding the participation (or lack thereof) of men in HIV programmes. By HIV programmes I mean Voluntary Counselling and Testing (VCT), support groups, PMTCT and ARV programmes. By focusing the research on what it means to be a man in such settings I hope that it will make a contribution towards the revision of current HIV programmes for men, as well as towards information about HIV in relation to heterosexual men.

The research is based on the knowledge and experiences of workers in the field of HIV. It is for this reason that I would like to invite you to participate in my study. Participation is completely voluntary. You have the right to refuse participation; any agreement to participate may be withdrawn at any time without penalty. There are no negative consequences that will arise from non-participation or information provided by you. As an informant to the study, you have the right to request that your personal details remain confidential. Recording of participants' names is solely for the researcher to be able to do follow ups where necessary. Please note that your responses will be completely confidential since your names will not be mentioned in the final report. Your responses will be treated with the utmost confidentiality and will not be shown to anyone other than the researcher and my supervisor.

I will be collecting data by conducting an hour-long semi-structured interview on a one-on-one basis. It would be preferable for the interview to be conducted at your clinic in a private room. In order for me to recall what was said in the interview, I will need to audio tape the discussion. You will be required to complete a consent form in this regard allowing me to do so. Should you wish to participate but prefer not to be audiotaped, you have an option to do so where your responses will be recorded in writing. You will be able to interact spontaneously in relation to questions asked. The interview consists of approximately five to six questions; therefore participation will involve taking part in an interview that will be about an hour in duration. The interviews will be conducted in English. Please feel free to make any inquiries regarding the study during or after the interview.

Should you be interested in seeing the results of the study, a copy of the report will be provided upon completion of the project. If you are interested in participating in my study, please fill in the attached forms.

Thank you for taking this time to consider participating in my study.

Yours sincerely,  
Zandi Dhlamini  
(0824775994)

## ***Appendix II: Informed Consent Form***

### **Informed Consent Form**

Participation in this study is completely voluntary. Should you wish to participate but prefer not to be audio taped, you have an option to do so where your responses will be recorded in writing. Recording of participants' names is solely for the researcher to be able to do follow ups where necessary. Participation may be terminated at any time without penalty. There are no negative consequences that will arise from non-participation or information provided by you. As an informant to the study, you have the right to request that your personal details remain confidential. Responses will be completely confidential; names will not be mentioned in the final report. Responses will be treated with the utmost confidentiality and will not be shown to anyone other than the researcher and the researcher's supervisor.

-----

I understand the purpose and procedure of the study. I also understand that information will be confidential and that I have the right to withdraw at any time, before and during the study.

I.....agree to participate in this research project.

Signature (participant).....

Signature (researcher).....

Date.....

### ***Appendix III: Consent to Record the Interview***

The researcher will have to audiotape record the interview in order to ensure that the data recorded during the interview is of good quality as well as quantity for the purpose of later reference.

-----

I.....hereby give consent for the audiotaping of the interview that I will be participating in I understand that the audio tapes will be kept in a safe place and will be destroyed after completion of the research. I accept that the interview will be recorded only for the purposes of this research project.

Signature (researcher).....

Signature (participant).....

Date.....



## ***Appendix IV: Interview Schedule***

### **1. DEMOGRAPHIC INFORMATION**

Name (optional).....

Age.....

Sex.....

Level of education.....

Job Title (if applicable).....

No. of years in this position.....

No. of years in the HIV field.....

### **2. INTERVIEW SCHEDULE:**

#### **2.1. Questions relating to health care workers perceptions on men accessing HIV programmes: (tick appropriate section):**

- What are your perceptions regarding men's participation in (VCT/ support groups/ARV programmes/ Couple VCT)?
- Do you perceive these programmes to be accessible?
- What informs your perceptions regarding men's participation and in accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- How do your perceptions impact on your interactions with men accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- When do your perceptions not impact your interactions with men accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- What are your perceptions about men with HIV positive partners?

**2.2. Questions relating to perceptions on men's experiences when accessing VCT, support groups, ARV programmes and Couple VCT: (tick appropriate section):**

- What do you perceive to be the men's experiences when accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- When do you perceive men to have these experiences in relation to (VCT/ support groups/ARV programmes/ Couple VCT)?
- How do you perceive men to understand their experiences when accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- Which age group of men do you perceive to be most likely to experience the most challenges in relation to accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be the consequences of these experiences in relation to men accessing (VCT/ support groups/ARV programmes/ Couple VCT)?

**2.3. Questions relating to perceptions on men's participation in (VCT/ support groups/ARV programmes/ Couple VCT)? (tick appropriate section):**

- What do you perceive to be the facilitator for men to seek (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be the challenges men experience when accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be their attitude towards accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be the concerns that bring men in for (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be men's feelings when accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- How do you perceive men to deal with their feelings when accessing (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be the manner in which men express themselves when accessing (VCT/ support groups/ARV programmes/ Couple VCT)?

- What do you perceive to be the support men require when accessing (VCT/ support groups/ARV programmes/ Couple VCT)?

**2.4. Perceptions regarding encouraging men participation in (VCT/ support groups/ARV programmes/ Couple VCT)?**

- What are your perceptions regarding current counseling/ therapeutic approaches in (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be the strengths of current therapeutic/ counselling approaches for men in (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be limitations of current counselling/ therapeutic approaches in (VCT/ support groups/ARV programmes/ Couple VCT)?
- What do you perceive to be other ways that would encourage men to seek (VCT/ support groups/ARV programmes/ Couple VCT)?

## ***Appendix V: Letters of Approval***

- Certificate from the University of the Witwatersrand University Ethics board
- Approval letter from Tshwarisanang couples clinic, Chris Hani Baragwanath Hospital
- Approval letter from Thembaletu HIV/AIDS clinic, Helen Joseph Hospital
- Approval letter from University of Johannesburg Campus Health for Kingsway and Bunting road campuses